Is There Hope For The Uninsured?

Most probably not, this seasoned economist concludes, although it is not for lack of good ideas and sound policy reasoning.

by Uwe E. Reinhardt

ABSTRACT: In an anecdote popular on the conference circuit, an American health policy analyst who has ascended to heaven asks God, “Will there ever be universal health insurance coverage in the United States?” “Perhaps,” sighs God, “but not in my lifetime.” This paper argues that this tale accurately describes the prospect of covering the uninsured in this country. Neither moral sentiments among a majority of U.S. political leaders, economic self-interest among those who would have to pay for universal health insurance, nor political pressure from the uninsured and likely-to-be-uninsured will provide a sufficiently strong imperative to move this country toward universal coverage soon, if ever.

For more than half a century now, Americans have had an ongoing series of inconclusive national “conversations” on the plight of the millions of Americans who do not have health insurance. These conversations have taken the form of conferences, town hall meetings, workshops, public hearings, television talk shows, a nationwide Covering the Uninsured Month, and so on. They have been informed by a steady stream of sophisticated survey research on the number of uninsured people, on their socioeconomic and demographic characteristics, and on the health and financial problems they face in health care, along with equally sophisticated policy analyses offering feasible strategies for achieving universal coverage.

The failure to achieve universal health insurance in this country, despite years of ceaseless effort, is thus not for want of a myriad of workable ideas on how to do so. Rather, it is a conscious call made by the majority of the nation’s political leaders. Although it has become obligatory for presidential candidates to talk about the issue in their campaigns, and some elected presidents have offered ambitious proposals in this regard—notably Truman, Nixon, and Clinton—in the end Congress has never viewed these proposals as a sufficiently worthwhile social goal to warrant the expenditure of the political capital the goal implies, which includes overriding the objections of a health care industry known for its generosity in financing political campaigns. Although giving lip service to the idea of universal
coverage, traditionally that industry has viewed any move toward it as a further intrusion of government into health care and a threat to its bottom line. Thus, while the plight of the uninsured has been debated from time to time by Congress and small incremental expansions of insurance coverage have been legislated, in the end proposals to move to full-fledged universal health insurance invariably have been shelved, whether Democrats or Republicans dominated Congress.

After more than half a century of futile policy research and inconclusive debate, marked by many political skirmishes and as many retreats as advances, it is fair to ask whether this country will ever move toward a health insurance system that might warrant the label “universal coverage.” My conclusion is, probably not. Neither moral sentiments among a majority of the nation’s political leaders, the pure economic self-interest of those who would have to pay added taxes for universal coverage, nor political pressure from Americans who are or are likely to be uninsured has provided a sufficiently compelling imperative for universal coverage. They most likely will not do so in the foreseeable future, either.

At any point in time in the next several decades, there are thus likely to be thirty to fifty million uninsured Americans—and conceivably more. At least half of the uninsured are too poor to afford state-of-the-art U.S. health care with their own resources. Many will continue to remain health care beggars in search of doctors, hospitals, and other providers willing to treat them on a charitable basis. Even if they do procure such care, their dire circumstance will rob them of the dignity and peace of mind that even the poorest patients in other nations have come to take for granted and that many people in the industrialized world—including a sizable minority of Americans—consider an important element in health care.

In this commentary I explain why this pessimistic forecast seems warranted now. I first comment on the terms “universal health insurance” and “uninsured.” Thereafter I explain step-by-step why I believe that this country, uniquely in the industrialized world, is unlikely to embrace the idea of universal coverage.

**The Meaning And Purpose Of Universal Coverage**

Although the definition of universal health insurance lies somewhat in the eyes of the beholder, at a minimum the concept implies that no American should lack access to health care because he or she lacks the ability to pay for it when needed and that no American should suffer serious financial distress or personal bankruptcy as a result of unpaid medical bills. That definition can accommodate a great variety of alternative health insurance systems with varying shades of financial protection for the individual.

The important point is that universal health insurance is not merely about access to health care and improved health status. To be sure, Jack Hadley’s authoritative recent survey of the literature leads him and several distinguished commentators on his work to the firm conclusion that “health insurance improves health and that better health leads to higher labor force participation and higher income.”
The Institute of Medicine’s (IOM’s) equally authoritative volume, *Hidden Costs, Value Lost: Uninsurance in America*, comes to the same conclusions. Both studies should give pause to opponents of universal coverage who claim that the uninsured merely are uninsured but do not want for needed care. They should also give pause to policymakers in a nation that claims among its national objectives the provision of equal opportunity to all. People in poor health and lacking health insurance cannot be said to have equal opportunities in a market economy.

In addition to providing access to needed care and equal economic opportunity, however, health insurance also provides families with protection from financial distress. That important social role should not be overlooked in our national “conversations” on the topic, as it often is.

To the advocates of universal coverage, there is something deeply troubling about the thought that a family should suffer foreclosure on a car or house or fail to send a capable youngster to college just because a member of the family has been stricken by, say, cancer or another serious illness. From their surveys on consumer bankruptcy, for example, Elizabeth Warren, Teresa Sullivan, and Melissa Jacoby conclude that “an estimated more than half a million middle-class families [per year] turned to bankruptcy courts for help after illness or injury in that year.” Unpaid medical bills represented a major component of the family’s debt.

Arguing that health care is just one of many basic consumer goods, and that people could have staved off bankruptcy simply by not “consuming” so much health care, is dubious. Unlike regular consumer goods, health care also has powerful moral dimensions that compel its use. In any modern society, a family with a member stricken with serious illness is subject to enormous social and personal moral pressure to follow certain steps prescribed by physicians, whose presumed expertise gives them strong persuasive power over patients. It matters not that these prescriptions may involve health care that clinical experts would judge after the fact to have been of dubious merit. Patients and family members confronted with serious illness are in no position to make those evaluations on the spot, if ever.

A major social function of health insurance, then, is to protect people from the financial consequences of the morally self-induced or socially prescribed use of health care, whatever its clinical merits. This point is most readily grasped by any parent with a seriously ill child, but it extends to all seriously ill patients and their families.

**The Heterogeneity Of The Uninsured**

From the perspective of health policy, the word “uninsured” is about as descriptive as is the word “animal” if one wanted to describe a schnauzer. Not all “unin-
sured” people, for example, represent a social problem in the sense that they are helpless victims of circumstance and require help from other members of society. A policy to achieve universal coverage, therefore, must be a mixture of a mandate on individuals to have at least catastrophic health insurance coverage along with a readiness to subsidize with public funds those Americans who could not afford even that level of coverage. Many advocates of universal coverage, of course, would argue that a clinically sound universal health insurance scheme would not leave noncatastrophic preventive care uncovered.

Alternative perspectives on the body count. In a recent publication, the Congressional Budget Office (CBO) provided a variety of estimates on the number of uninsured people in 1998, using different surveys and definitions of uninsured. The CBO estimated that twenty-one to thirty-one million Americans were uninsured for the entire year 1998, and as many as fifty-nine million were without health insurance at some point in 1998. Of the latter, only 30 percent (about eighteen million) were estimated to have remained uninsured for more than twelve months.

In between these two definitions is the number of Americans who tend to be uninsured at specific points in time during the year (when the survey was taken). In 1998 that number was estimated to range between 39 and 42.6 million, depending on the survey. This is the number most commonly used in the literature and the media to describe the health insurance status of Americans. Of such Americans, about 80 percent are estimated by the CBO to have been uninsured for more than twelve months.

Income and insurance coverage. It is well known that lack of health insurance falls as income rises. While 17 percent of the total nonelderly U.S. population lacked health insurance in 2001, that percentage was 37 in households with incomes below the federal poverty level, 27 in households with incomes between 100 percent and 199 percent of poverty, and only 6 in households with incomes above 300 percent of poverty. Exhibit 1 conveys a snapshot of the economic status of Americans

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**EXHIBIT 1**
Characteristics Of The Uninsured, As A Percentage Of The Federal Poverty Level, 2001

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Percentage of Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100 percent</td>
<td>36%</td>
</tr>
<tr>
<td>100–199 percent</td>
<td>29%</td>
</tr>
<tr>
<td>200–299 percent</td>
<td>16%</td>
</tr>
<tr>
<td>300 percent or more</td>
<td>19%</td>
</tr>
</tbody>
</table>

found to be without health insurance at a specific point in time.

Of the thirty-nine to forty-two million or so Americans estimated by snapshot surveys to be uninsured at a specific point in time during 2001, about 19 percent are estimated to belong to families with an income of 300 percent above poverty, defined in 2001 as $42,384 for a family of three. Many of these individuals or families probably could have afforded to procure with their own resources at least a catastrophic health insurance policy, if it were offered to them in the marketplace at premiums comparable to those paid for members of large, heterogeneous risk pools. If they had to buy insurance in the individual insurance market, however, and if they were chronically ill, they might find it beyond even their higher budgets. Even as well-situated a person as the late former mayor of New York City, John V. Lindsay, for example, eventually could not afford his out-of-pocket outlays for the treatment of a variety of chronic illnesses late in his life, prompting a compassionate Mayor Rudy Giuliani to appoint him to two no-show city jobs that came with municipal health insurance.8 Less well connected Americans in his situation might have gone bankrupt.

Families with incomes below 300 percent of poverty, however, will find it increasingly difficult in the decade ahead to afford health insurance coverage with their own resources, if they are not implicitly subsidized through employer-sponsored health insurance. Furthermore, employers of relatively low-skill, low-wage workers also will find it increasingly difficult to carve funds for employer-sponsored health insurance out of their gross wage base, which ultimately must carry that load.

Consider, for example, a firm that can afford for a particular type of employee a maximum annual dollar debit of, say, $40,000 to the payroll expense account (for gross wages paid the employee plus all fringe benefits and taxes paid on behalf of employees). Hereafter, that total debit to the payroll expense account is called “affordable gross compensation” for that type of employee.

Suppose general price inflation in the firm’s products and annual productivity gains permitted the employer to increase that affordable gross compensation by 4.5 percent per year for the next decade or so, which means that a decade hence the firm could afford gross compensation of about $62,000 for this type of employee.

According to the most recent Henry J. Kaiser Family Foundation/Health Research and Educational Trust (HRET) Survey of Employer-Sponsored Health Benefits (2002), the average employment-based premium for family health insurance coverage in 2002 was very close to $8,000.9 Whether formally paid by the employer (as so-called employer-paid health insurance) or by the employee (in the form of a paycheck deduction), that $8,000 premium would have constituted 20 percent of gross compensation for that type of employee. If that insurance premium rose by an average compound rate of, say, 10 percent for the next decade—a rate of increase much below the 15 percent or so annual premium increases re-
corded in recent years—then the family premium a decade hence would be $20,800, or about 35 percent of the then affordable gross compensation of $60,000. If, on the other hand, premiums continued to rise at their recent trend of 15 percent per year for the next decade, then more than half of the affordable gross compensation (54 percent) would be absorbed just by the health insurance premium of $32,360.

The gist of the preceding calculations is that current economic trends drive the employer-based health insurance system into a perfect storm that will force more and more employers with low-productivity and hence low-wage workers to jettison them from coverage. Under those circumstances, the decades-old dream of universal health insurance could be realized only if members of the upper-income strata were willing to provide ever larger subsidies for the roughly bottom 30 percent or so of the income distribution.10 The question has been and remains what might compel such a fiscal transfer from the haves to the have-nots in our democracy. Before exploring that question, it may be well to examine current estimates of what a move to universal health insurance might cost.

The Cost Of Covering The Uninsured

In estimating the cost of an extension of health insurance to near-universal levels, we must make a distinction between two cost figures that are frequently confused in the debate on the uninsured: (1) the additional national health expenditures that universal coverage would trigger (hereafter called the NHE cost), and (2) the additional government outlays that the policy would require. The latter cost figure typically exceeds the former, depending on the design parameters of policies used to achieve universal coverage.

■ Additional NHE costs. In a paper titled “How Much Health Care Do the Uninsured Use, and Who Pays for It?” Jack Hadley and John Holahan estimated that the uninsured now receive health care costing about $100 billion, an estimate accepted as valid in the previously cited IOM volume.11 In their sequel paper titled “Covering the Uninsured: How Much Would It Cost?” the two researchers present two alternative estimates of the additional NHE cost incurred on the additional health care that the currently uninsured would be likely to use, if they had health insurance.12 If that insurance were the typical private coverage now held by middle- and low-income American families, then, according to the authors, their additional use of health care would add $69 billion a year to total national health spending. On the other hand, if the uninsured were folded instead into public insurance programs (such as Medicaid and the State Children's Health Insurance Program, or SCHIP) that pay providers much lower fees, the additional health care then likely to be used by the uninsured is estimated to add only $34 billion to annual national health spending. This range of increases would have raised total national health spending in 2001 by 3–6 percent, and the percentage of gross domestic product (GDP) absorbed by health care would have risen less than one percentage point.
Additional government spending. The preceding NHE cost estimates indicate only what the additional health care not being used now by the uninsured would cost, if they were insured. The additional government spending that policy would entail would be higher for two reasons.

First, some of the expenditures already made on behalf of or by the uninsured would most likely be shifted to the government under universal health insurance. In their first paper, Hadley and Holahan estimated that of the roughly $100 billion of health care the uninsured used in 2001, 38 percent was covered by private and public insurance (for uninsured people covered at least part of the year), 34.5 percent represented what providers had reported as “uncompensated care” (care billed at whatever prices were used for that purpose, but without payments received), and 26 percent was paid for out of pocket by the uninsured themselves.

If the purpose of public policy in this area were to protect American families from financial distress, then presumably some of this out-of-pocket spending by the uninsured would be shifted from the uninsured to the government's budget. Similarly, if the uninsured had coverage, providers presumably would be paid some or all of the $34.5 billion of “uncompensated care” they now report to have given, although as a group they would also lose the sundry public subsidies they now receive for treating the uninsured (such as disproportionate-share hospital, or DSH, money from the federal and state governments). Most probably, then, the additional government spending triggered by a move to universal coverage naturally would exceed the incremental NHE cost of $69 billion calculated by Hadley and Holahan, by a sizable margin.

A second reason why government's outlay for a move to universal coverage would exceed the cost of the pure additional NHE costs is the likelihood that some already insured families might give up their private coverage to “crowd” into whatever new, heavily subsidized public program is established. The cost to the government of such a “crowding-in” effect could be small or large, depending on the design parameters of the move toward universal coverage.

If one assumes an additional government outlay of at least a $100 billion in the base year of a new universal coverage program and a rise in per capita health spending by an average annual compound rate of 6 percent in the ensuing decade, then the additional ten-year budget outlay occasioned by a move to full-fledged universal coverage might be $1.3 trillion. On the other hand, if per capita health spending rose by 10 percent per year, the additional ten-year budget outlay would be $1.6 trillion.

Although these seem to be large numbers, they appear less so when compared with the roughly $130 trillion of GDP likely to be generated over the same time span, if GDP grows at an average compound growth rate of 5 percent over the next decade. Even so, in thinking about the prospects for universal health insurance and the plight of the uninsured, the key question is whether American society would be willing to countenance the kind of tax-and-transfer estimated above.
What Imperatives Might Bring About Universal Coverage?

The United States might adopt universal health insurance for one or a combination of the following reasons. First, the nation's political leadership might view it a moral imperative to provide every American family with the physical and fiscal protection that comes with health insurance, as it was in Taiwan, whose political leadership introduced universal coverage in that country in 1995. Second, the nation's political leaders might believe that providing the uninsured with more timely care, rather than withholding subsidies until they are desperately sick, would actually be a sound economic proposition for the nation. Third, political leaders might respond to the voting power of the uninsured and likely-to-be uninsured. Are any or all of these potential drivers powerful enough to move the nation toward universal health insurance?

Moral sentiments among political leaders. The federal budget is a document through which the nation's political leaders reveal what moral trade-offs they are willing to make in the name of the people. In this regard, the federal budget of 2001, passed by a bipartisan majority of Congress and signed by President George W. Bush, is the clearest official statement yet of the leadership's moral sentiment regarding the plight of the uninsured. Exhibit 2 renders that sentiment graphically.

The United States began the new millennium looking at a cumulative ten-year surplus of the federal operating budget (also called “on-budget”) of $3.1 trillion. The president and other politicians, of course, talked about a $5.6 trillion surplus of what is called the “unified budget.” That budget, however, implicitly treats as expendable money a projected ten-year “off-budget” surplus of $2.5 trillion, which represents mainly the projected ten-year surpluses in the Social Security and Medicare trust funds. In principle, these surpluses should have been set aside.
“The $3.1 trillion surplus would have been more than ample to move toward universal health insurance without raising taxes.”

to cover future outlays by those programs. In fact, Congress and the Bush administration have acted as if the entire off-budget surplus can legitimately be spent on routine government operations, such as the civil service, defense, and even some $800 billion over ten years in farm subsidies.

Evidently, given the calculations presented above, the $3.1 trillion operating (on-budget) surplus would have been more than ample to allow this nation to move toward universal health insurance without raising taxes or dipping into the (off-budget) trust funds. Neither the Bush administration nor Congress proposed to do so. Instead, the bulk of the surplus was returned to taxpayers in the form of a massive tax cut. Although at the time that tax cut was rationalized essentially as a classic Keynesian demand stimulus for a sluggish economy, the added health spending from a move to universal coverage would have triggered an equally strong Keynesian demand stimulus. The difference between these two fiscal measures is that they enter the private economy at different ends of the nation’s income distribution.

Mainly as a result of conscious budget decisions in early 2001, by August 2001, one full month before the terrorist attacks of September 11, the projected erstwhile operating (on-budget) surplus of $3.1 trillion had melted down to only $847 billion, within the span of about half a year. True, the surplus melted in part because economic conditions had deteriorated (reducing the projected surplus by $238 billion) and for other technical reasons not rooted in legislation (a reduction of $177 billion). But by far the bulk of the meltdown reflected the decision by the administration and Congress to enact the huge tax cut of 2001. With the added interest cost on public debt that this tax cut implies, it accounted for somewhere of close to $1.7 trillion dollars of the meltdown in the ten-year projected on-budget surplus.

To put this tax cut into broader perspective, let me note that in 2000 governments at all levels in the United States jointly claimed one of the smallest shares of GDP (29.6 percent) among countries in the Organization for Economic Cooperation and Development (OECD), second-lowest only to Japan (27.1 percent). The corresponding average for the OECD as a whole was 37.4 percent and that of OECD Europe 39.9 percent. By international standards, Americans do not appear to be heavily taxed.

Since 2001 the U.S. federal budget outlook has steadily deteriorated further, partly as a result of deteriorating economic conditions, but also as a result of a further major tax cut enacted in 2003. In its Analysis of the President’s Budgetary Proposals for Fiscal Year 2004 dated March 2003, the CBO projects that the president’s budget would result in an on-budget deficit of $4,389 trillion and a unified budget deficit...
of $1.8 trillion, even after all surpluses in the Social Security and Medicare trust funds have been spent.20

For health policy analysts, the question emerging from recent federal budgets is this: If the politically dominant segment of Congress did not feel morally obligated to assist low-income, uninsured Americans in the face of the huge projected budget surplus at the beginning of 2001, would anyone expect these leaders to do so now, or in the decade ahead, as they face the growing federal budget deficits and mounting external debt that their own decision brought about? After all, the plight of the uninsured now can be brushed aside once again with appeal to the deteriorating budget, the staple rationale for inaction in the past.

The purely economic case for universal coverage. The proponents of universal health insurance have for years tried to make a purely economic case—sometimes called the “business case”—for universal coverage. In Hidden Costs, Value Lost, for example, the IOM estimated the annualized cost of the diminished health, productivity, and shorter life spans of Americans who lack health insurance to be $65–$130 billion for each year of health insurance forgone.21 That figure would, of course, carry much weight in the economist’s imaginary world that is ruled by an omniscient, benevolent dictator. It is unlikely to impress politicians in a nation of self-styled individualists who may share a common belief in the Constitution but who do not otherwise feel strongly bound together with others by a sense of social solidarity—certainly not in health care. After all, most of the benefits identified by the IOM—such as longer, healthier lives; absence of physical discomfort; and greater financial security—would accrue to the uninsured themselves, rather than to those who would have to pay added taxes to procure those benefits.

It may be argued that those who would pay the added taxes for universal coverage would benefit indirectly from it after all, because they would be spared the so-called cost shift by which part of the cost of the health care the uninsured do receive is said to be billed by the providers of health care to insured patients. Furthermore, because the uninsured usually do not receive timely care, the critically needed care they ultimately do get is needlessly expensive. One thinks here of a failure to treat chronic diseases like asthma, diabetes, or hypertension with relatively cheaper pharmaceutical therapy that could have helped avoid more expensive hospital episodes.

There is something to this argument; however, if one accepts the previously cited estimates by Hadley and Holahan as plausible, the argument loses force.22 As the authors note, “Even taking uncompensated care into account, the full-year uninsured received about half as much care ($1,253 per person in 2001) as the privately insured received ($2,484).” From a purely selfish economic perspective of those who would have to finance a move to universal coverage, leaving the nation’s uninsured in their current predicament turns out to be cheaper than stepping up to underwrite with added taxes a move to universal coverage.

It may also be argued that providers of health care—notably hospitals—have a
strong economic interest in seeing the uninsured covered, because they now bear the burden of treating many uninsured patients on an “uncompensated” basis. The argument is not persuasive, for two reasons. First, appeal to the burden that the uninsured are said to visit on providers has long furnished them with a shield whenever Congress seemed intent upon stricter cost control. Second, the true, net economic burden of the uninsured on providers—certainly on the hospital sector—is much smaller than seems widely supposed.

According to Hadley and Holahan, the uninsured in 2001 received about $35 billion of “uncompensated care.” Did that sum come out of these institutions’ proverbial bottom line? Almost surely not. First, many providers got public subsidies of various sorts to offset that burden. More importantly, the $35 billion figure reflects the fully allocated cost of such care, which includes the amortization of fixed costs that would have been incurred by the providers in any event.

A more appropriate measure of the uninsured’s burden on providers would be the incremental costs of uncompensated care—that is, costs that would not have been incurred if that care had not been given. Although some individual providers may, indeed, bear a disproportionately large net economic burden for uncompensated care, for the system as a whole the true incremental net cost of such care is bound to be much smaller than seems widely believed—for example, the widely reported 6 percent or so of total expenses reported by hospitals to be “spent” on uncompensated care. Furthermore, to the extent that the much lower incremental costs of charitable care are recovered from private insurers and other self-paying patients, they are unlikely to constitute a sizable economic burden on these payers, either.

A quite different economic rationale for covering the uninsured might be sought in the labor market. Uniquely in the United States, health insurance is part of the total compensation of employed people and a powerful come-on for certain types of highly skilled labor used by competing employers to attract scarce talent. Indeed, as the Wall Street Journal reported recently, many corporate boards in the United States apparently feel compelled to have the firm’s top executives fully reimbursed for all out-of-pocket expenditures that the firm’s formal health insurance policy demands from other employees.

It is well known by now that most uninsured Americans belong to families headed by one or two full-time workers. Does the labor market for these workers provide a compelling argument for offering them health insurance? It does not. Typically, these low-income workers do not have the unique skills that might compel employers to compete for them with attractive health insurance benefits. Many of them can be replaced by immigrant labor that is not very demanding. Therefore, there usually is no compelling economic reason to be particularly nice to these workers in the labor market. They are under enough constant economic pressure to work hard for the rest of society, even if they are not offered health insurance on the job. In fact, after an illness, they may even work harder for the rest
of society, if they can, to pay off their medical bills.

Finally, it seems plausible to argue that employers bear some cost of avoidable absenteeism or low productivity triggered by lack of access to timely health care by uninsured employees. Its avoidance through universal health insurance, however, would not accrue to taxpayers who would have to fund a move to universal coverage.

Overall, then, I am not persuaded that a purely economic rationale for embracing universal coverage would ever move a majority of the nation's political leaders to do so. The distribution of the benefits from universal coverage would not coincide with the incidence of its cost. In a nation of self-centered individualists without much of a sense of social solidarity, that divergence works against the prospect for universal coverage.

The political imperative for universal coverage. If neither moral sentiments among a majority of the nation's political leaders nor pure economics lends sufficient political support for a move to universal health insurance in this country, might pure self-interest among low-income Americans speak sufficiently loudly at the ballot box to force upon the political process a move in that direction?

Remarkably, as is shown in Exhibit 3, at the ballot box the voice of the uninsured appears muted. It can be inferred from Exhibit 3 that more than half of potential voters in income classes with something to gain from a move to universal coverage turned their back on the congressional elections in 1998.

Given that the lack of health insurance is heavily concentrated in the lower-income strata of society, it is not surprising that in a retrospective on the 2002

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EXHIBIT 3
Percentage Of Eligible Voters Voting In The 1998 Elections, By Annual Income Level

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Percentage of Voters Who Voted</th>
</tr>
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<tbody>
<tr>
<td>$75,000 or more</td>
<td></td>
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<tr>
<td>$60,000–$74,999</td>
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<td>$50,000–$59,999</td>
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<tr>
<td>Less than $5,000</td>
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Percent in income group who voted

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SOURCE: Christine Eibner, Department of Politics, Princeton University, personal communication, 22 January 2003.
congressional elections, Robert Blendon and his colleagues found that health care was not the most pressing issue on voters’ minds. Furthermore, they report in Exhibit 3 of their paper that 30 percent of the respondents to their opinion survey who agreed with the statement that “helping the uninsured get health insurance coverage is the most important issue in deciding their vote (from a list of six issues)” were likely nonvoters. By contrast, only 21 percent of likely voters agreed with that statement.

In a paper titled “Economic Inequality and Political representation,” delivered in August 2002 to the American Political Science Association, Larry Bartels concluded from his statistical analysis of senators’ roll-call behavior that they “appear to be much more responsive to the opinions of affluent constituents than to the opinions of constituents with modest incomes...The preferences of constituents near the top of the income distribution are even more influential, while those at the bottom fifth receive little or no weight.” Given the apparent voting pattern by income class and the manner of campaign financing in the United States, Bartels’ finding probably does not come as a surprise to many. For present purposes we merely note that the political imperative for a move to universal health insurance in this country does not appear to be particularly strong.

Conclusion

The thrust of this commentary has been to argue that the United States is unlikely to embrace universal health insurance for this country soon, if ever, because neither a sense of social solidarity, pure economic self-interest of those who would have to pay added taxes for it, nor political pressure from the uninsured furnishes the requisite political force to induce a majority of the nation’s political leaders to embrace that idea. Admittedly, this pessimistic conclusion is in the nature of a conjecture by an economist who cannot claim expertise in the analysis of this nation’s complicated politics. Even so, four decades of close observation of U.S. health policy makes that conjecture a good wager.

If this conjecture is on the mark, the question arises whether there is any merit in producing the vast body of research on the uninsured that comes forth year after year, the similarly steady stream of policy proposals for a move to universal coverage, and the series of “conversations” had on the topic all over the country year after year, including the periodic hearings on it before Congress. My answer to this question is an unqualified yes.

Although the political deck seems powerfully stacked against universal health insurance in the United States, every so often the stars do align, as the saying goes, to make breakthroughs in public policy possible. It was so with the original enact-
ment of Medicare in 1965, with the enactment of the seemingly doomed 1986 general income tax reform legislation, and with SCHIP in 1997. Thus, the champions of universal health insurance are well advised to have at their fingertips, at all times, the requisite, up-to-date analyses that policymakers might want to see on those occasions, and also up-to-date policy proposals that could be quickly enacted and implemented. It is the health policy analogue of permanent military preparedness.

To be sure, when hard-won incremental breakthroughs in the fight on behalf of the uninsured have come from time to time, they often have appeared as small steps up on a downward-rolling escalator. It is thus that the number of uninsured has grown in this country over time. The less fortunate of society, however, would be much worse off without those hard-won incremental steps on their behalf. It should make the fight on behalf of the uninsured worthwhile to their champions among policy analysts and to the tenacious minority of politicians who champion their cause in Congress.

An earlier version of this paper was presented at “Health Insurance in America: Challenges and Prospects,” the 2003 Carolina Health Summit, in Chapel Hill, North Carolina, 6–8 April 2003.

NOTES


5. One thinks here of the “overuse and misuse” of health care attributed to our health system by clinical experts, such as the authors of the IOM’s Crossing the Quality Chasm: A New Health System for the Twenty-first Century (Washington: National Academies Press, 2001), 3.


11. J. Hadley and John Holahan, “How Much Medical Care Do the Uninsured Use, and Who Pays For It?,” Exhibit 3, 12 February 2003, www.healthaffairs.org/WebExclusives/Hadley_Web_Excl_021203.htm (22 July 2003), and IOM, Hidden Costs, Value Lost, Table ESI.


13. Calculated using the equation \( T = X[(1 + g)^N-1]/g \), where \( T \) is total additional health spending over the future period of \( N \) years, \( X \) is the incremental spending in the first year, and \( g \) is the annual growth in spending.

14. In 2001 the U.S. GDP was $10.02 trillion. It is estimated to be $17.4 trillion by 2012, which implies an average annual compound growth rate of about 5 percent. See S. Heffler et al., “Health Spending Projections for 2002–2012,” Exhibit 1, 7 February 2003, www.healthaffairs.org/WebExclusives/Heffler_Web_Excl_020703.htm (22 July 2003). Applying the equation given in the previous footnote to these numbers implies a total GDP over the period 2002-2012 of about $131 trillion.


17. In principle, the annual Social Security surpluses could have been invested in Euro bonds—that is, dollar-denominated bonds purchased and held by foreigners. When the bonds come due decades hence, foreign taxpayers would have to repay them, and not future generations of American taxpayers. Alternatively, the surpluses could have been used to retire the U.S. federal debt, forcing the holders of that debt to recycle the funds into the private U.S. economy. Either way, future generations would have been less burdened than they will be if all Social Security surpluses are routinely spent on current government operations.


20. CBO, An Analysis of the President’s Budgetary Proposals for Fiscal Year 2004 (Washington: CBO, March 2003), Table 1.


22. Hadley and Holahan, “Covering the Uninsured.”

23. Hadley and Holahan, “How Much Medical Care Do the Uninsured Use?”

24. Only for providers operating at full capacity would these incremental costs be the net profits forgone by treating the uninsured instead of treating paying patients.


28. L.M. Bartels, “Economic Inequality and Political Representation” (Paper presented to the American Political Science Association, Boston, Massachusetts, August 2002).