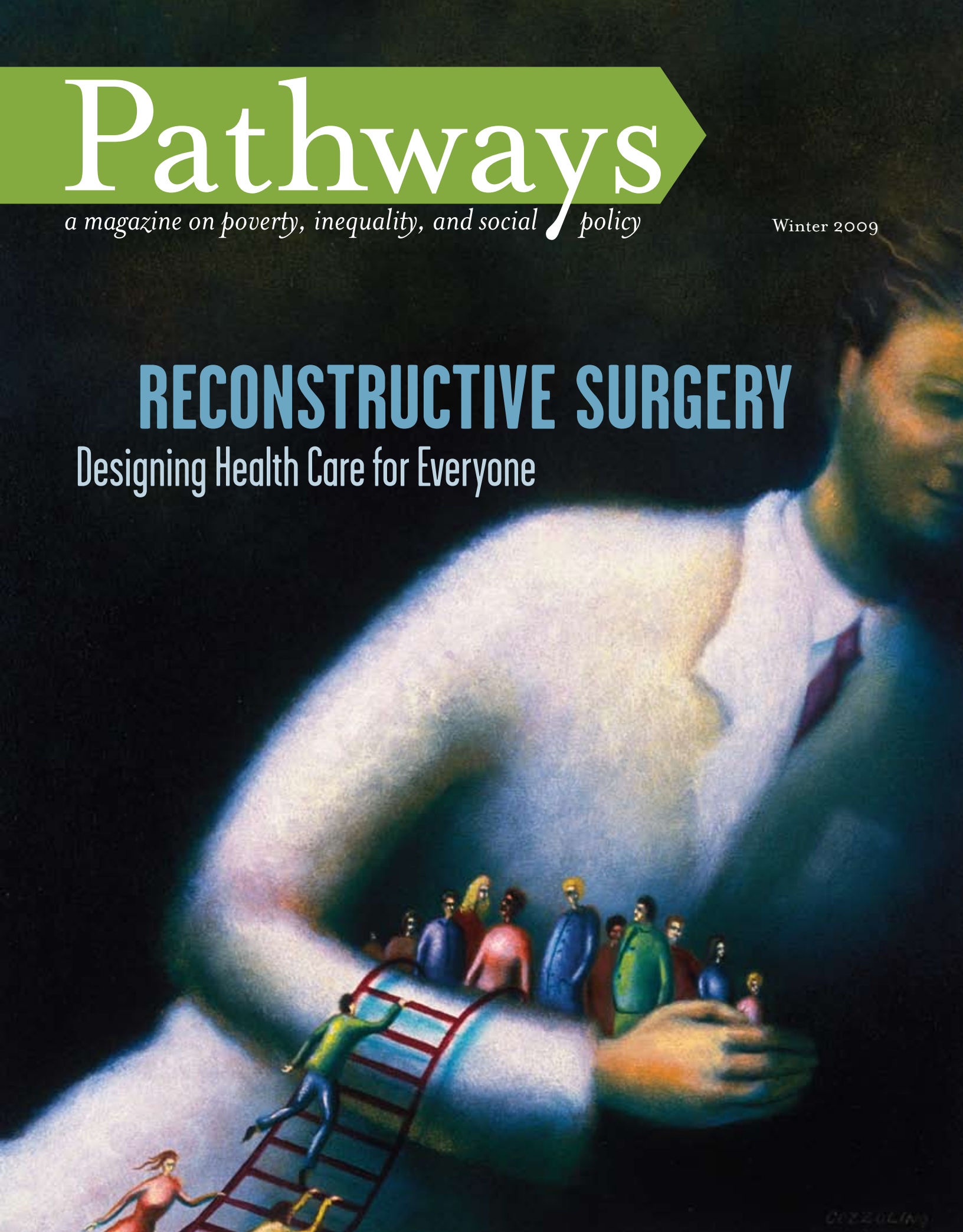
Pathways
a magazine on poverty, inequality, and social policy
Winter 2009

RECONSTRUCTIVE SURGERY

Designing Health Care for Everyone



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Editors' Note

The idea of a stork delivering a neatly bundled baby is a cultural touchstone freighted mainly with feelings of magic, happiness, and hope. Like most fairy tales, the stork tale is also tinged with a darker feel, a foreboding that owes mainly, we suspect, to its reminder that life is rather like a lottery. How, after all, does the stork decide where to drop its precious bundle? If it's dropped down a rich family's chimney, the child will likely have a long, prosperous, and healthy life. If the same bundle is instead dropped into a poor family's house, the child's life comes closer to the Hobbesian ordeal, not necessarily brutish, but more likely a nastier and shorter existence. The idea of a birth lottery is especially disturbing when it comes to the meting out of something as fundamental as health. The poor child is consigned to dangerous neighborhoods, stressful jobs, and inadequate health care, while the rich child is conveyed, solely by the accident of birth, all the health that money can buy.

This is to emphasize the obvious point that health and health care are distributed in ways that clearly violate our commitment to equal opportunity. The unlucky children are both *directly disadvantaged* by virtue of living shorter and less healthy lives and *indirectly disadvantaged* insofar as such poor living conditions and health then set them back in the competition for schooling, jobs, and good wages. While the case for reducing disparities is sometimes made by referencing a fundamental "right to health care," one can easily forgo the language of rights and rest the case on a straightforward commitment to equality of opportunity.

The simple rationale for our cover story: Given that an attempt to reform health care is looming, we had best be clear on whether we want such reform to take on the problem of inequality. It is troubling that the health care debate to date has focused almost exclusively on access to insurance and has ignored the many other ways in which health inequalities are generated and may be redressed. The contributors to this issue were thus asked to step back and develop a more comprehensive approach to reducing health inequalities.

Although our contributors diagnose the problem similarly, their prescriptions are quite diverse. Unlike the debate on insurance schemes, which has by now rigidified, there is evidently much to resolve in deciding how best to take on health disparities. For some of our contributors, emphasis is placed on the disparity-inducing effects of our insurance system. Indeed, Jonathan Gruber argues that a main reason disparities have become so extreme is that we subsidize the (excessive) health expenditures of the privileged, while Robert Moffit makes the case for a disparity-reducing decoupling of insurance from employment. But disparities can also be addressed outside the insurance system. For example, Barbara Wolfe argues that they are best reduced by upgrading health care for poor mothers and children, while Karen Davis and Kristof Stremikis describe how patient-centered medical homes can be a centerpiece of a disparity-reducing agenda.

Would it cost too much to adopt these reforms? Especially in the midst of an economic crisis? The costs-too-much refrain, conventional though it is, ignores the even higher costs of business as usual. Because health disparities lead to underinvestments in prevention and degrade our workforce, we pay a collective price for insisting on so much inequality, a price that may be our Achilles' heel as we struggle to compete with other countries that develop and maintain their human capital more efficiently. As we set to the task of reform, leaving inequality and disparities off the table may be the real cost that we can't afford to pay.

—David Grusky & Christopher Wimer, Senior Editors

Consumer Indebtedness

and the Withering of the American Dream

BY TERESA A. SULLIVAN

In the summer of 2008, the Standard and Poor's 100 quietly dropped a low-performing stock and replaced it with one performing better. Though the event was not unusual, the two stocks involved were surprising: MasterCard replaced General Motors.[1] It was once said that what was good for General Motors was good for the nation. This may have been a bit of hyperbole, but General Motors has provided access to the middle class for thousands of workers.

Despite the popularity of MasterCard's tagline, "For everything else, there's MasterCard," it is less clear that MasterCard has contributed much to the sustenance of the American dream. In fact, an increasing number of American families find themselves crushed under consumer debt. If major steps are not taken soon, the American dream could collapse.

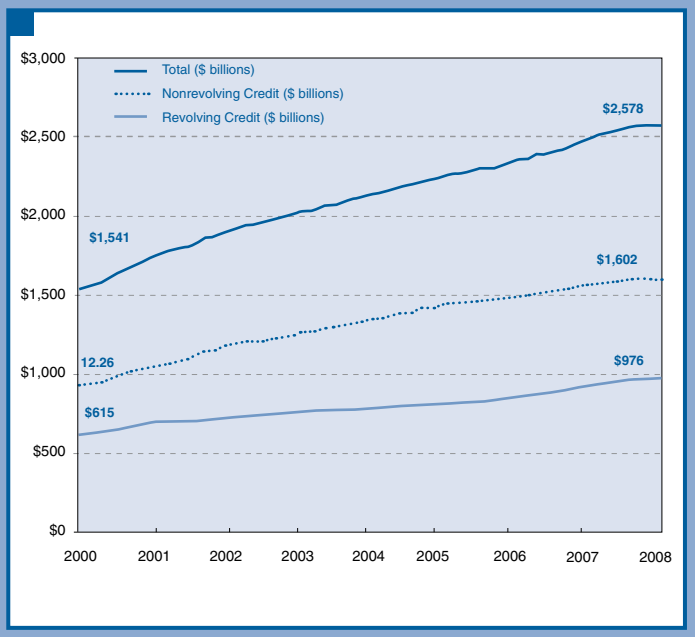
A mere six months ago, when I presented data on trends in consumer indebtedness, I characterized those trends as alarming. But little did I know just how bad things might get. A solution has become more difficult to envision, let alone implement. Below, I provide up-to-date trend data on the state of consumer indebtedness, data showing that more and more Americans are finding themselves deep in debt. I then review the sea changes in the financial system and credit markets that brought this about and discuss how the rise in indebtedness is occurring just as asset values are declining. I close by arguing for policies that might combat these trends.

Consumer Indebtedness

Since 2000, total outstanding consumer credit has grown by over $1 *trillion* (see Figure 1). Divided by the number of adults in the United States over age 18, this works out to an increase of approximately $4,400 per person. Approximately two-thirds of this increase has come in the form of nonrevolving debt, while the remaining one-third comes in the form of revolving debt. (Revolving debt includes credit card debt, while nonrevolving debt includes mortgages or auto loans.) Despite some recent flattening in the *rate* of acquiring new debt, the volume of existing debt is staggering—and repayment is getting harder.

Repayment is a function of disposable income, and consumers (at least homeowners) are taking on more debt as a percentage of their disposable income. Figure 2 shows trends in two key indicators of consumers' debt burden: the debt service ratio and the financial obligations ratio (DSR and FOR, respectively). The Federal Reserve defines the DSR as the percentage of disposable personal income devoted to consumers' minimum estimated debt payments for their mortgages and consumer debt. The FOR adds to the DSR numerator the estimated payments for automobile leases, rent for tenant-occupied property, homeowners' insurance, and property tax payments. By both measures, many Americans are increasingly burdened by debt.

FIGURE 1. Trends in Consumers' Outstanding Credit (in billions of dollars, 2000–2008)



Source: Federal Reserve

Taking just the DSR, we see that Americans' debt payments were over 12 percent of their disposable income in 2000, and this has risen to just over 14 percent of disposable income in 2008. Given the additional obligations that many Americans bear, the situation is even worse than the DSR suggests. Homeowners' total financial obligations have risen from over 15 percent of disposable income in 2000 to over 17.5 percent of disposable income in 2008. Renters have been more successful in reducing the extent of their financial obligations, though their obligations relative to their income have always been much higher than for homeowners. Keep in mind that these percentages reflect only consumers' minimum estimated debt payments. For credit card debt, high interest rates will continue to apply to the balance. A more reasonable repayment schedule would involve a far higher commitment of disposable income. The important point is that, at least for homeowners, even minimum estimated debt payments are taking up an increasing proportion of their income.

Cause for Alarm

It might well be argued that the foregoing increases in indebtedness aren't all that substantial. Indeed, given the dire economic forecasts of our time, one might well have expected even steeper increases than those revealed here. There are two main reasons the trends in Figures 1 and 2 are so troubling. First, as unemployment continues to rise, an increasing number of Americans won't have the income to pay off their debts.

A December 2008 report from Congressional Oversight Panel for Economic Stabilization, headed by my longtime colleague Elizabeth Warren, puts it as follows:

> The crisis affects Americans' ability to pay their bills, to secure their retirement, to continue their educations, and to provide for their families. The unemployment rate is the highest it has been in fourteen years. In the last three months, 1.2 million Americans lost their jobs; 533,000 in November 2008 alone. Service sector employment levels, in particular, fell far faster than expected last month. One in ten mortgage holders is now in default, unable to make payments on their homes. More than 200,000 families and small businesses filed for bankruptcy protection in the last two months.[2]

Taken together, the rise in consumer indebtedness and the crumbling of the economy suggest dire consequences for large swaths of the American public. With ever greater outstanding financial obligations, any shock such as unemployment is likely to cast many an American family into financial ruin.

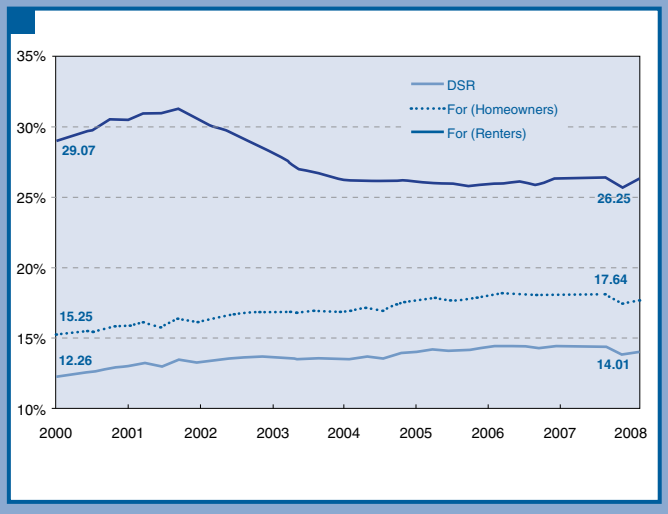
If income streams become a less reliable source of debt relief, how about assets? Might those who are deep in consumer debt and out of work at least convert their assets to cash to pay it off? In answering this question, note that the average family has two main assets, the family home and the retirement fund. Until the last year or two, home prices were rising in most parts of the country, and lenders made it very easy for homeowners to borrow against their increasing equity. Home equity loans had been advertised widely and were considered smart financial instruments by some experts because the interest on home mortgages, including home equity loans, is deductible on federal income tax. Credit card companies also got into the act, offering home equity lines of credit.

As is now well known, a vicious cycle began to eat away at home values in almost all parts of the country, and foreclosures from adjustable-rate mortgages and home equity defaults have increased. Many neighborhoods, including upscale ones, have numerous vacancies. Ordinary home sellers have trouble finding buyers, in part because buyers are having trouble finding financing. And those homes must now compete on the market with foreclosed homes being sold at fire-sale prices by banks and other lenders. Most home-owning families have lost net worth over the past 12 months because of the erosion of the value of their home, and this has happened even if they did nothing at all in the credit or real estate markets.

But the news gets even worse. With the stock market collapse, many families have suffered dramatic losses in the value of their other substantial asset: their retirement (and related) accounts. The overvaluing of risky subprime mortgages affected many lenders and many investors in the secondary market, with eventual disastrous effects on the stock market more generally. Although recent legislation may help prop up the market, there are other sources of market instability. Among these are energy prices, the eroding value of the dollar, and the very high federal deficit.

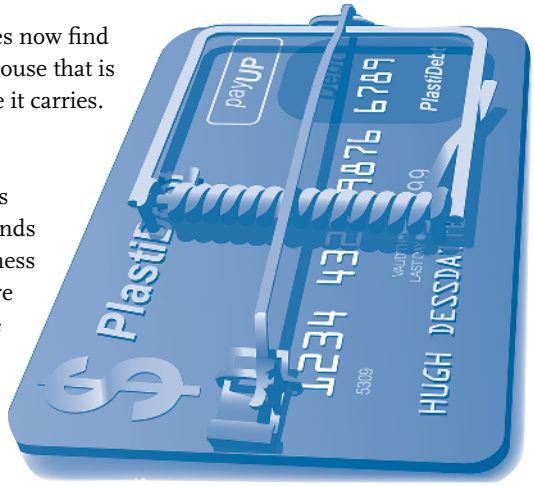
Thus, the average family stands to lose value in both of its major investments—the home and the retirement fund. These sources cannot, then, be relied upon to pay back debt. In the

FIGURE 2. Trends in Consumer Debt Burdens (as a percentage of disposable income)



Source: Federal Reserve

case of home mortgages, many families now find themselves "upside down," or with a house that is suddenly worth less than the mortgage it carries.



Rebuilding Consumer Solvency

How might we begin digging ourselves out? While reversing the long-term trends toward mounting consumer indebtedness is undoubtedly an enormous task, there are a number of practical steps that we can take now to prevent consumers from being irrevocably buried in debt and to maintain their solvency. At the same time, we can provide the proper framework of incentives so that consumers change the patterns of behavior that led to mounting indebtedness in the first place. I outline some of these changes below.

Debt relief and bailouts: After Congress approved approximately $750 billion dollars for the U.S. Treasury to bail out various companies struggling to stay afloat, large numbers of companies came out of the woodwork looking for a slice of the government-approved money. And within months, the Treasury had doled out approximately half of the approved funds.

Little was done, however, to ensure that those companies being bailed out in turn took steps to protect consumers. Under the government's Capital Purchase Program (CPP), which allows the treasury to inject money into companies in return for preferred stocks and equity warrants in those companies, more could be done to ensure that program beneficiaries provide debt relief to consumers as a precondition for receiving funds. As it stands, companies may receive funds without doing anything to modify consumers' loans or provide foreclosure relief to ensure that actual consumers and borrowers are "bailed out" as well. Making relief a condition for CPP funding would be a promising step for future disbursals of government aid.

It would also be wise to consider other modifications to government aid, such as those proposed by FDIC chairwoman Sheila Bair. In particular, Bair has strongly advocated redesigning incentives for companies to engage in loan modifications for consumers. These would include reimbursing mortgage servicers for costs associated with loan modifications and arranging for the FDIC to share the risks involved in consumer re-defaults. As it stands, many firms are not participating in programs designed to ensure that troubled borrowers stay afloat, so proposals to provide a proper framework of lender incentives could help to expand the scope of loan modification policies. These changes, however, are merely stopgaps to prevent the crisis from deepening.

Reduce borrowing: Also necessary are long-term strategies to reduce consumers' borrowing and encourage saving. Numerous studies in behavioral economics document how saving is much more likely when it is presented to consumers as the default rather than merely as an option. The Earned Income Tax Credit, for example, could be reformed to promote automatic savings. Government programs that match savings could also be used to promote desired behavior, though such programs may have to wait until brighter fiscal days.

Although we probably want savings to increase in the long run, it is not clear whether such changes are best implemented in the midst of the current crisis. Because banks are hoarding rather than lending, the effects of promoting savings might not be felt immediately (in the form of trickle-down investments), and a direct Keynesian stimulus is of course most everyone's prescription for now.

Lastly, stronger regulation and enforcement of credit-granting companies should be undertaken. In particular, Congress and legislatures should reconsider whether there is some level of interest rate that could again be regarded as usurious. The regulatory requirement to provide factual information to tobacco users has been at least partially successful. Requirements for simple information for debtors—such as the number of months required to repay a balance at the minimum rate of repayment—could empower more consumers to make better choices.

A Bailout for the American Family

Americans are gradually but increasingly becoming buried by debt. According to recent congressional testimony by Professor Robert Lawless, total outstanding consumer debt now exceeds annual national personal income in the United States.[3] At the same time, the American consumer is being hit by a disintegrating economy, with neither income nor assets a secure source of repayment. The confluence of these two trends is a "perfect storm" threatening consumer solvency and the foundation of the American dream. The main solution, as described above, is to direct the bailout to American families. Although longer-range reforms to promote savings over debt accumulation are desirable, for now we are in the perverse position of needing to encourage spending, if not by consumers, then by the government.

NOTES

1. http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aFsz.09VBIdc, "Mastercard to Replace," July 10, 2008

2. Available at: http://cop.senate.gov/hearings/index.cfm

3. Available at: judiciary.senate.gov/pdf/08-12-04LawlessTestimony.pdf

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Healthily Ever After?

Is marriage indeed the silver bullet that supporters of marriage promotion policies claim? The long-standing argument here is that mothers are better off when they marry: better off financially, better off in terms of their mental and physical health, and better off in terms of their children's well-being. New research by Kristi Williams, Sharon Sassler, and Lisa M. Nicholson indicates that, when it comes to the mothers' physical and mental health, what really matters isn't just getting married but finding a *high-quality* and *enduring* marriage.

Using data from the National Survey of Families and Households, Williams and colleagues examine changes in health following marriage for childless women and single mothers. For both groups of women, they find declines in psychological distress following marriage, but only if that marriage endures. Moreover, single mothers do not enjoy improved physical health after marriage, as their marriages tend to be of lower quality. In some cases, the mental and physical health of single mothers actually deteriorates when they enter and then exit marriages, leaving them worse off than if they had remained unpartnered all along.

The simple, unadorned marriage promotion initiative can therefore backfire. For marriage to help single mothers, what's needed is a high quality and enduring union. If we promote marriage at all costs and without regard for quality or endurance, we may end up with poor marital choices, low-quality unions, and a perverse deterioration in well-being.

Kristi Williams, Sharon Sassler, Lisa M. Nicholson. 2008. "For Better or For Worse? The Consequences of Marriage and Cohabitation for Single Mothers." *Social Forces,* 86(4), 1481–1511.

"The Poor Will Always Be with You" (Matthew 26:11)

Is poverty intractable? Have all advanced, industrial countries failed to reduce poverty? We can learn more about the presumed intractability of poverty by comparing advanced industrial countries to learn whether any of them have experienced recent, substantial declines in child poverty.

This is just the tack taken by Wen-Hao Chen and Miles Corak in their analysis of changes in child poverty rates in 12 countries. Using the Luxembourg Income Study, they find that during the 1990s only three countries—the United States, the United Kingdom, and Norway—experienced substantial declines in child poverty. The decline in these countries is not attributable, moreover, to simple demographic changes, like average parental age or number of children per household. Although compositional changes in the labor market, such as rising female labor force participation, did contribute to a reduction in child poverty, an even more important source of this reduction, especially in Norway and the United Kingdom, was growing income transfers to families with children. The simple conclusion: Much headway against child poverty can be made by combining full employment policy with aggressive income transfers.

Wen-Hao Chen and Miles Corak. (2008). "Child Poverty and Changes in Child Poverty." *Demography,* 45(3), 537–53.

Choosing to Choose

In many school districts, parents now have the opportunity to choose among several public schools to which they might send their children, with the options often including schools with a distinctive curricular focus or test scores that are higher than what prevails in their neighborhood school. These "public-choice" plans, which are intended to help close achievement gaps and help disadvantaged youth escape struggling schools, have not always delivered well on that objective. The main problem is that a surprising number of parents choose to remain in their neighborhood school or find the choice process so daunting they don't even engage in it. If public-choice plans are to work better, it is therefore important to find ways to make it easier to exercise choice.

This was precisely what Justine S. Hastings and Jeffrey M. Weinstein examined using a unique set of experiments in Charlotte-Mecklenburg, N.C. In the past, parents in this district were asked to enter an online system and search for schools to which they might send their children, an approach that might well deter some parents. Over the course of several years, the district shifted the way in which choice could be exercised, abandoning reliance on the online system and instead sending parents a simplified three-page fact sheet on the available choices. In a separately conducted field experiment, an even more simplified one-page fact sheet was sent to parents. The results were striking in two ways. First, by offering simplified information to parents, there were large increases in the number of parents choosing schools with higher test scores. And, secondly, the children who attended these schools performed substantially better on the tests. The public-choice model can work well for struggling students, but parents need a little help in becoming savvy, "choosy" consumers.

Justine S. Hastings and Jeffrey M. Weinstein. 2008. "Information, School Choice, and Academic Achievement: Evidence from Two Experiments." *Quarterly Journal of Economics,* 123(4): 1373–1414.

THE NEW REPUBLICAN POPULISM?

The conventional wisdom in U.S. politics has been that the Republicans are the party of business while the Democrats are the party of labor. But will this old formula give way as both parties reposition themselves in response to new economic and social conditions?

According to new research by Gary Miller and Norman Schofield, a fundamental shift is occurring in today's Republican party, with the ascendant socially conservative wing of the party driving many pro-business (but socially moderate or liberal) members into the arms of the Democratic party. This dynamic plays out, for example, in recent high-profile Republican defections, such as Vermont's James Jeffords or Kansas' Mark Parkinson. But it is also playing out among rank-and-file members. If the defections continue, Miller and Schofield suggest that the Democrats could become the party representing the interests of business, leaving the Republicans to increasingly court the economic as well as social concerns of their now more blue-collar constituents. In the short run, such defections will blur the differences between the two parties, perhaps making both parties more moderate on business and labor issues. But in the long run this realignment could produce a new Republican party in the William Jennings Bryan populist mold—a Republican party that is socially conservative and anti-business.

Gary Miller and Norman Schofield. 2008. "The Transformation of the Republican and Democratic Party Coalitions in the U.S." *Perspectives on Politics,* 6(3): 433–450.

The Tightening Vise

The current financial crisis has, of course, led to a substantial tightening of credit markets. Much of the journalistic focus has been on middle class families and how they can't access equity in their houses or secure credit card debt. This begs the question: To what extent are the poorest and most disadvantaged able to use credit to smooth earnings shortfalls caused by shocks like unemployment? Although having too much credit and debt can of course harm disadvantaged households, having access to some credit can help those who lack financial assets and need to get by during what they hope will be temporary hard times.

Using data from two long-term surveys of income and consumption (the Survey of Income and Program Participation and the Panel Study of Income Dynamics), James X. Sullivan provides some concrete answers to this question. He finds that those with moderately low levels of assets are able to borrow during difficult times at the rate of approximately 11 cents in unsecured debt per dollar of earnings lost. Although the moderately poor can therefore buffer shortfalls to some extent, Sullivan also finds that those at the very bottom of the assets distribution do not increase their borrowing at all in the face of earnings losses. This means that our most disadvantaged households are not countering the effects of adverse shocks to their income. It follows that, unless proactive steps are taken, the very poor will become exceedingly vulnerable as credit markets continue to tighten and unemployment rates continue to grow.

Sullivan, X. James 2008. "Borrowing During Unemployment: Unsecured Debt as a Safety Net." *Journal of Human Resources,* 43(2): 383–412.

(More Than) a Few Good Men

It is well known that high-poverty neighborhoods often have too much crime, too much violence, and too many youth with extensive criminal records. But why is there so much crime in high-poverty neighborhoods? We simply don't know enough to fully answer this question. There are, of course, many hypotheses about the sources of crime, including the "role model" hypothesis that has juveniles succumbing to the temptations of crime and delinquency because they lack stable male role models and aren't exposed to viable alternatives to crime. Rigorous evidence on the role model hypothesis has to date been sparse.

In a recent study, Karen F. Parker and Amy Reckdenwald address this gap by examining whether cities with more male role models—older, employed, married men—had lower rates of juvenile crime and violence. Their results suggest that male role models do in fact lead to lower rates of crime and violence. And this effect is substantial in size: It turns out that disadvantaged neighborhoods have so much crime in large part because such neighborhoods haven't many male role models.

It follows that pro-employment policies are triply advantageous for workers, children, and victims. Although they are obviously great for the workers who get the jobs, they are also great for the children who are now protected from the lure of crime and for neighborhood residents who, by virtue of this protection, are now less frequently victimized.

Karen F. Parker, Amy Reckdenwald. 2008. "Concentrated Disadvantage, Traditional Male Role Models, and African-American Juvenile Violence." *Criminology,* 46(3), 711–735.

Be Cool, (Don't) Stay in School

Some scholars describe the path to upward mobility for the poor as straightforward: Go to school, stay in school, work hard, and eventually such investments will pay off. There is little disagreement with the standard prescription that the working poor get ahead by acquiring educational credentials. Indeed, the 1996 welfare reform was supposed to move low-income women off welfare caseloads and into education, training opportunities, and the workforce.

Is welfare reform working in this classic way? New research suggests that, quite perversely, welfare reform may have *decreased* the likelihood that low-income women complete high school or attend post-secondary schooling. Using data from the Current Population Survey, Dhaval Dave, Nancy Reichman, and Hope Corman report that welfare reform surely succeeded in moving women off welfare rolls, but it was also associated with a 20 to 25 percent falloff in the likelihood that they attended high school or college. These large effects were mitigated in states that supported education as an alternative to work. Moreover, they were reversed among teenage girls, for whom welfare rules required education as a precondition for receiving benefits.

What are the implications for assisting the working poor? As the current recession atrophies the low-wage labor market, there is an opportunity to resist tendencies to push untrained and uncredentialed workers immediately into the labor force. A second round of welfare policy might follow the lead of those states that emphasized education and training, thereby building an infrastructure of better-skilled labor.

Dhaval Dave, Nancy Reichman, and Hope Corman. 2008. "Effects of Welfare Reform on Educational Acquisition of Young Adult Women." NBER Working Paper #14466.

Divergent Desistance

In the 1980s, cocaine was considered a drug for the moneyed elite, and indeed it was a prominent symbol of the elite's excesses during that period. However, cocaine eventually lost its position as an elite drug in the 1990s, when it seemingly became increasingly popular among the poor and less educated. Why did this new socioeconomic disparity in the opposite direction open up so suddenly? The standard answer: Falling cocaine prices and the emergence of crack cocaine exposed the drug to a new pool of low-income users.

Is such conventional wisdom on the mark? Using nationally representative data from the National Longitudinal Survey of Youth, Richard Miech finds no evidence for the conventional "recruitment hypothesis" that, because cocaine suddenly became cheap enough for poor people to buy, the socioeconomic disparity reversed in direction. Rather, what happened suggests an alternative hypothesis: Upper-income and more educated users responded to new information on the drug's health risks and used their greater resources to more adeptly desist from cocaine usage. In fact, Miech finds that poor people did not expand usage after 1990, but rather the well-off went from a high probability of using prior to 1990 to a near-zero probability thereafter. At least for cocaine use, the socioeconomic disparity reversed because more advantaged users found ways to stop a costly habit, not because of a massive influx of less-advantaged users discovering the drug. The clear policy implication is that we would do well to develop among less-advantaged users the same resources to desist that now exist among more-advantaged ex-users.

Richard Miech. 2008. "The Formation of a Socioeconomic Health Disparity: The Case of Cocaine Use during the 1980s and 1990s." *Journal of Health and Social Behavior*, 49, 352–366.

"Girl Power" and Mathematics Achievement

Larry Summers, President Obama's pick for head of the White House's National Economics Council, was famously ousted as the president of Harvard University after suggesting that the gender gap in mathematics achievement might have a partly genetic foundation. Although his comments were clearly impolitic, many have suggested that we ought mainly to ask whether there is any science behind them.

A new study by Andrew M. Penner tackles just that question by marshaling an impressive array of data. Using data from the Third International Mathematics and Science Study, the World Bank, the United Nations, the International Labour Organization, the World Values Survey, and the International Social Survey Programme, Penner shows that there are wide cross-national variations in the size of the gender gap in math achievement. These differences take on, moreover, a fascinating pattern. The gender differences at the top of the math distribution are smallest in those countries with the greatest labor market equality between men and women (e.g., more gender-balanced professional and managerial sectors) and with the greatest status equality between men and women (e.g., greater representation of women in politics and leadership positions). It seems that girls perform at very high levels in math in those societies in which they can expect a full and equal shot at succeeding.

Andrew M. Penner. 2008. "Gender differences in extreme mathematical achievement: An international perspective on biological and social factors." *American Journal of Sociology,* 114, S138–S170.

Performance-Based Inequality?

The dramatic increase in income inequality since the 1970s is one of the most spectacular developments of our time. This increase is typically linked to technological change and a corresponding growth in the demand for highly skilled labor, to globalization and the disappearance of manufacturing jobs, to declines in the strength of unions, and to the influx of low-skill immigrants into the labor market. These conventional narratives ignore, however, the possibility that changes in *how* we pay workers are partly responsible for the spectacular growth in inequality. While many commentators point to changes in CEO and executive pay, there has also been a widespread trend in recent years toward performance-based pay for salaried workers of all types. This trend takes the form of more commissions, bonus pay, and piece-rate contracts. Is it possible that such pay changes have contributed to wider trends in income inequality?

According to Thomas Lemieux, W. Bentley MacLeod, and Daniel Parent, the answer to this question is a definitive yes. By examining national data from the Panel Study of Income Dynamics, these researchers find that (1) performance pay increased substantially since the late 1970s, and (2) wages in performance-pay jobs are markedly more unequal than in jobs with other types of pay mechanisms. The rise of performance pay turns out to account for approximately a quarter of the total increase in wage inequality between the late 1970s and early 1990s (and for a much larger fraction of the increase in wage inequality above the 80th percentile). It follows that income inequality increased partly because of meritocratic changes in the labor market that allowed firms to reward the productivity of their best workers.

Thomas Lemieux, W. Bentley MacLeod, and Daniel Parent. Forthcoming (2009). "Performance Pay and Wage Inequality." *Quarterly Journal of Economics,* 124.

Poisons, Place, and Race

The problem with residential segregation, conventional thinking goes, is that those living in less privileged neighborhoods have fewer opportunities to make money and get ahead. In other words, racial or ethnic minorities consigned to high-poverty neighborhoods are cut off from job opportunities, valuable social networks, positive role models, and a host of related mobility-producing resources. Although these economic costs of segregation are clearly important, segregation may also have direct effects on *health* because of differential exposure to environmental risks (e.g., poisonous air pollutants).

Liam Downey and Brian Hawkins consider this possibility in a new article linking national census data to an Environmental Protection Agency database on toxic air pollutants. Two striking findings emerged. First, black Americans were substantially more likely to live in areas with greater exposure to toxic environmental pollutants, thereby exposing them to greater health risks than whites or Hispanics. Second, blacks with high incomes were quite successful in escaping this exposure to toxic pollutants, as differences in exposure between high-income blacks and other high-income workers were sharply reduced. It follows that poor blacks were most at risk of being exposed to dangerous air pollutants.

There are not just economic costs to living in less desirable neighborhoods; there are health costs as well. Although high-income blacks can relocate to environmentally safe areas, low-income blacks often remain stuck, and hence bear both the economic and environmental health burdens of living in bad neighborhoods.

Liam Downey, and Brian Hawkins. 2008. "Race, Income, and Environmental Inequality in the United States." *Sociological Perspectives,* 51, 759–781.

Undocumented Attainment

There has been much debate about the fairness of offering state aid and services to undocumented immigrants. Is it fair, for example, to offer in-state tuition rates to undocumented state residents while charging out-of-state tuition to others (including documented immigrants) who happen to reside out of state?

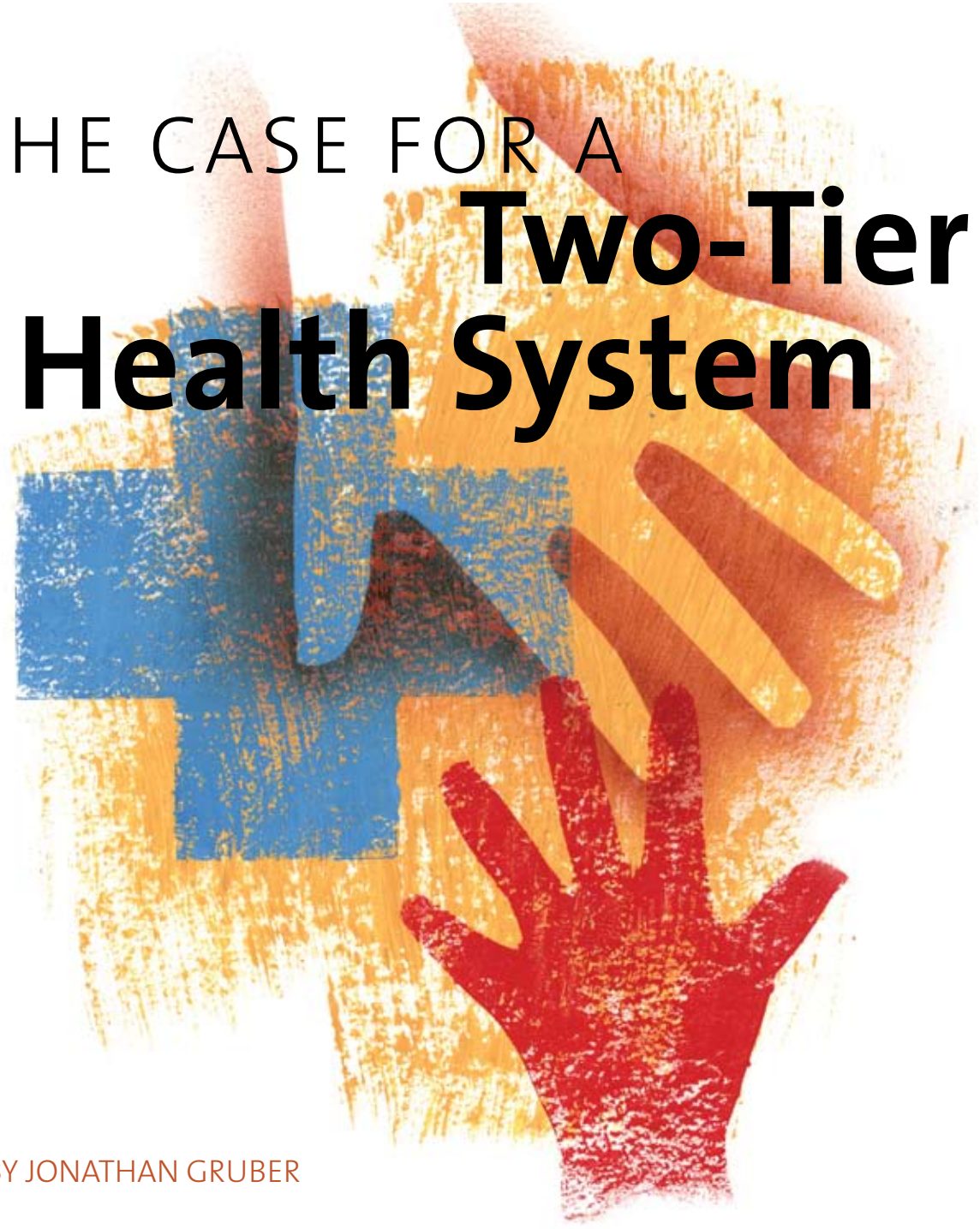
The question of fairness should not be ignored, but it is best addressed after considering the concrete effects of altering state tuition policies. It is particularly important to know the consequences of offering in-state tuition rates to the undocumented. Do undocumented state residents attend college at much higher rates when they are offered in-state tuition? Does attendance simultaneously decrease for other groups?

In a new study using the Current Population Survey, Neeraj Kaushal attempts to provide these baseline facts. The results reveal that providing in-state tuition rates to undocumented Mexican youth is associated with substantial increases in their educational attainment (e.g., a 31 percent increase in college enrollment and a 33 percent increase in the proportion of Mexican young adults with a college degree). Moreover, and even more strikingly, this policy is not associated with any decreases in attainment for other groups. If anything, rates for other groups actually went up (given that many colleges, such as community colleges, simply expand to meet higher levels of demand).

How can in-state tuition rates be such an unmitigated good? Because many Mexican neighborhoods and families encompass a mix of different citizenship statuses (e.g., citizens, documented, undocumented), Kaushal suggests that pro-education policies for undocumented workers can raise awareness and educational attendance across wider networks and citizenship categories. It seems that benefits to one group may "trickle out" through such cross-cutting networks and ultimately benefit all.

Neeraj Kaushal. 2008. "In-state Tuition for the Undocumented: Education Effects on Mexican Young Adults." *Journal of Policy Analysis and Management,* 27, 771–792.

THE CASE FOR A Two-Tier Health System



BY JONATHAN GRUBER

THESE ARE EXCITING TIMES for those who want to fundamentally reform the U.S. health care system by establishing universal health care coverage. There are sizeable Democratic majorities in both houses of Congress and a Democratic president who made universal coverage a central pledge of his campaign. Indeed, Senators Baucus and Kennedy are hard at work on universal coverage legislation, and Senators Wyden and Bennett have already submitted a bipartisan bill that would accomplish that goal.

But while Democrats (and some Republicans) have long agreed on fundamental health reform centered on universal insurance coverage, that is where the agreement ends. There are a wide variety of reform models, and a number of different ways to get to universal coverage. Many argue that the only logical approach to such reform is a single-payer system, as in Canada, where one monopoly government insurer provides coverage for the entire population. Every resident of Canada is entitled to a uniform package of insurance benefits with limited patient cost-sharing. This approach has a number of major efficiency advantages, including lower administrative costs and maximum bargaining power for the insurer (the government) in negotiations with providers, which keep medical costs much lower than in the United States. It also may lead to much more equalized outcomes of the health care system than does a piecemeal system of insurance.

At the same time, such an approach is highly unlikely to succeed in the United States for two reasons. First, it would displace the majority of insured Americans who are largely satisfied with the health insurance they receive from their employers. Second, it would require nationalizing an industry, private health insurance, with more than $500 billion in revenues per year. These barriers are not likely to be overcome in the foreseeable future.

For this reason, policymakers have been turning to a new model that I label "incremental universalism": moving to universal health insurance coverage by building on the existing system of (largely employer-based) private health insurance and filling in the cracks through which the uninsured are likely to fall. The example most commonly used to illustrate this model is the ambitious health reform that began in late 2006 in the state of Massachusetts. This plan had several key features: heavily subsidized insurance for low-income residents that is very comprehensive (with limited copayments and no deductibles); market reform for other residents so that everyone else in the uninsured and small-group insurance markets purchase through a pooled market where prices cannot vary by health (and only in a limited way by age); and an individual mandate that imposes large fines on residents who do not have health insurance coverage unless they meet a set of narrow exemption guidelines (exempting about 15 percent of the uninsured on income grounds).

This plan leaves intact the employer-based system for firms with more than 50 employees. Most of the insurance coverage in the state continues to be provided via this employer-based model. It is perhaps for this reason that the plan was able to pass.

Thus far, the plan has been quite successful, with the most recent estimate reporting an uninsurance rate of only 2.6 percent, by far the lowest in the nation and perhaps as close to universal coverage as is feasible in the United States. Costs have been high, but in line with projections of about $1 billion for fiscal year 2009. This implies a cost of about $2,000 per newly insured person, which is very low by the standard of other options for increasing health insurance coverage.

Universal Coverage and Inequality

Single-payer and "incremental universalism" are just two examples of models that can lead the United States to universal health insurance coverage. Yet these two models, as well as other alternatives, can have very different implications for the *inequality* of health outcomes in our society. Indeed, the primary concern for advocates of universal coverage should be this level of inequality. For the most advantaged members of society today, both health care and health outcomes are excellent; for example, the white infant mortality rate in the United States is comparable to rates in other developed nations. The fundamental problem with the U.S. health system, and the one reflected in our poor international comparisons, is the terrible outcomes of the most disadvantaged members of society: the black infant mortality rate in the United States is twice the white rate, and is higher than the rates in either Barbados or Malaysia.

In this essay, I step back to discuss the determinants of health inequality and how it plays into the structure of universal coverage. Health status inequality in any nation will be the product of several factors. The first, and most important, is inequality in non-medical factors. This ranges from nutrition to exercise to smoking to safety, and is largely beyond the influence of the medical system. These non-medical sources of inequality should be the primary focus of any campaign to reduce health disparities. Perhaps the single best source of improvement in the health of Americans over the past 50 years has been the reduction in cigarette smoking, and a serious gun control policy might do as much or more for the health of Americans as any expansion of insurance coverage. Although these issues around non-medical inequality are both important and fascinating, they are beyond the purview of this article.

Of the remaining health inequality that is amenable to medical intervention, the three factors that matter are uniformity of *coverage*, uniformity of *access*, and uniformity of *quality*. By uniformity of coverage, I mean uniformity in the comprehensiveness with which medical care is covered by insurance, and the costs that individuals have to pay out of pocket to use that care. By uniformity of access I mean uniformity in the availability of nearby physicians and hospital care. And by uniformity of quality I mean uniformity in the skill level of the providers to which individuals have access.

In practice, it is infeasible to achieve perfect uniformity along all three of these dimensions. Consider uniformity of access. Given the enormous differences in population density in

countries such as the United States, it would be incredibly inefficient to guarantee every citizen a physician within 5 miles of his or her home, or even perhaps within 25 miles.

Minimum Standards

So the question becomes: What should developed nations strive for as standards in these areas? I believe that the right approach is to move toward an explicit two-tier medical system, whereby society sets minimum standards in each of these areas, but then allows individuals to buy higher coverage, access, or quality using their own resources. In fact, such is the approach used by most single-payer nations that have an explicit national health program: They allow individuals to buy extra insurance or care using their own funds.

But this is not the approach currently used in the United States. There are no explicit standards for what constitutes minimum acceptable standards for coverage, access, and quality. As a result, we have many individuals falling below any reasonable acceptable minimum in each category, while most others end up subsidized to levels well above such minima. This extremely unequal patchwork system must be reformed. At the same time, it is fiscally impossible to bring every American up to the highest standard of coverage, access, and quality. Therefore, the question becomes: What is an acceptable minimum standard that can form the basis for a two-tier system?

The best example of this issue is the generosity of insurance coverage. Forty-seven million Americans have no health insurance coverage, and that figure is only going to grow due to recent economic hardships. Yet the vast majority of the remaining Americans actually have *too much* insurance coverage, in that they are induced to use medical care beyond the point where it is cost effective. This is clear from the famous RAND Health Insurance Experiment of the 1970s. In this experiment, individuals were randomly assigned to plans with more or less individual cost-sharing; some received health care for free, while others had to pay 95 percent of the costs up to an out-of-pocket limit that was roughly $5,000 in today's dollars. As one might expect, the individuals who were less comprehensively covered used less health care; for example, those for whom health care was free used 50 percent more care than those who had to pay 95 percent of the costs. What was more surprising was that, on average, they were in no worse health. That is, the marginal health care utilization that was induced by more generous insurance coverage did not improve health.

Why do individuals typically have insurance coverage that covers care that does not seem to improve health? There are a variety of reasons, but one is that the government subsidizes them to do so. Individuals who receive their health insurance through their employers pay taxes on their wages but not on the value of their health insurance. This tax subsidy, which amounts to foregone revenues to the government of over $250 billion/year (making it the third largest health care program in the United States), induces individuals to purchase excessively generous insurance coverage.

Given these facts, how should health insurance coverage be reformed to increase equality in a fiscally responsible manner? First and foremost, all citizens must be guaranteed some form of insurance coverage. But that base level should be no more generous than is

. . . the vast majority of the remaining Americans actually have too much insurance coverage, in that they are induced to use medical care beyond the point where it is cost effective.

necessary to produce health efficiently. This would be achieved by a plan that made individuals pay their up-front costs of health care, but with an out-of-pocket maximum that is income-related so no family is bankrupted by their health care needs.

At the same time, the government should allow individuals who wish to purchase more generous coverage to do so. Without this "escape mechanism," there will be enormous pressure to continually ratchet upward the generosity of the base level to meet the needs of higher-income individuals who prefer, and can afford, to be over-insured. However, a key change must be to end government subsidies to insurance coverage that are above that base level: If higher-income individuals want to buy more generous coverage, they should be allowed to, but not with government-subsidized dollars. Such a two-tier system can then ensure that all have cost-effective insurance coverage, while also reducing government expenditures on health care.

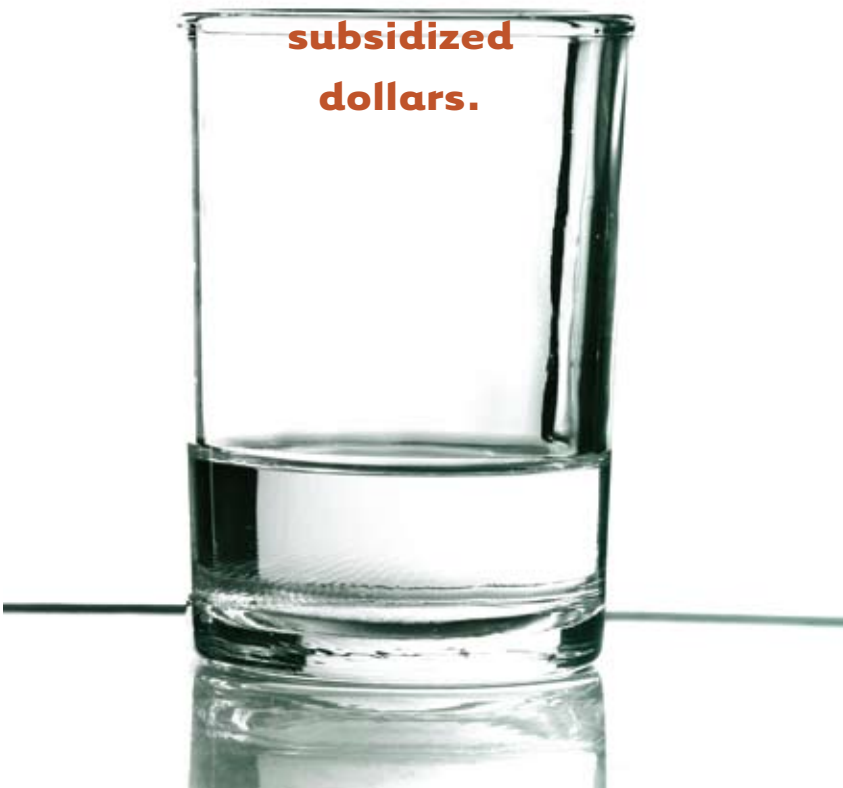
Another example of an explicit two-tier approach is with respect to quality of care. As researchers at Dartmouth and elsewhere have emphasized, there are enormous discrepancies in the quality of care that is delivered around the United States. For example, sensible preventive measures, such as the use of beta blockers after a heart attack, are ignored by a sizeable share of primary care doctors and specialists around the nation.

A clear move toward equality in health would be to both penalize poor-quality care and reward high-quality care through reimbursement incentives. Once again, society must address the key question of a minimum level of quality that it is willing to accept for all citizens. Having defined that, both public and private insurers need to pay providers only if they meet those minimum standards. Such "pay for performance" measures are slowly being adopted in the United States, but in a haphazard way. Once again, however, insurance plans may adopt higher standards for quality and charge more as a result. Individuals who want to pay more for such plans should not be restricted from doing so, but should not be subsidized in any way for those purchases.

In summary, the United States could move to a health care system that is much more equal—but it is impossible, and impractical, to demand perfect equality of health outcomes, or even of health insurance inputs. Rather than hold out for perfect equality, the focus of action should be in two areas. The first is defining a universally accepted minimum, then ensuring that all citizens receive that minimum, be it with respect to health insurance generosity, quality of care, or other features. The second is to allow individuals to purchase above that minimum—but not to subsidize such purchases through the government. Any public resources devoted to this problem should be devoted to financing an acceptable minimum, not to promoting choices beyond that level.

Jonathan Gruber is Professor of Economics at the Massachusetts Institute of Technology and formerly Deputy Assistant Secretary for Economic Policy at the Treasury Department.

If higher income individuals want to buy more generous coverage, they should be allowed to, but not with government-subsidized dollars.

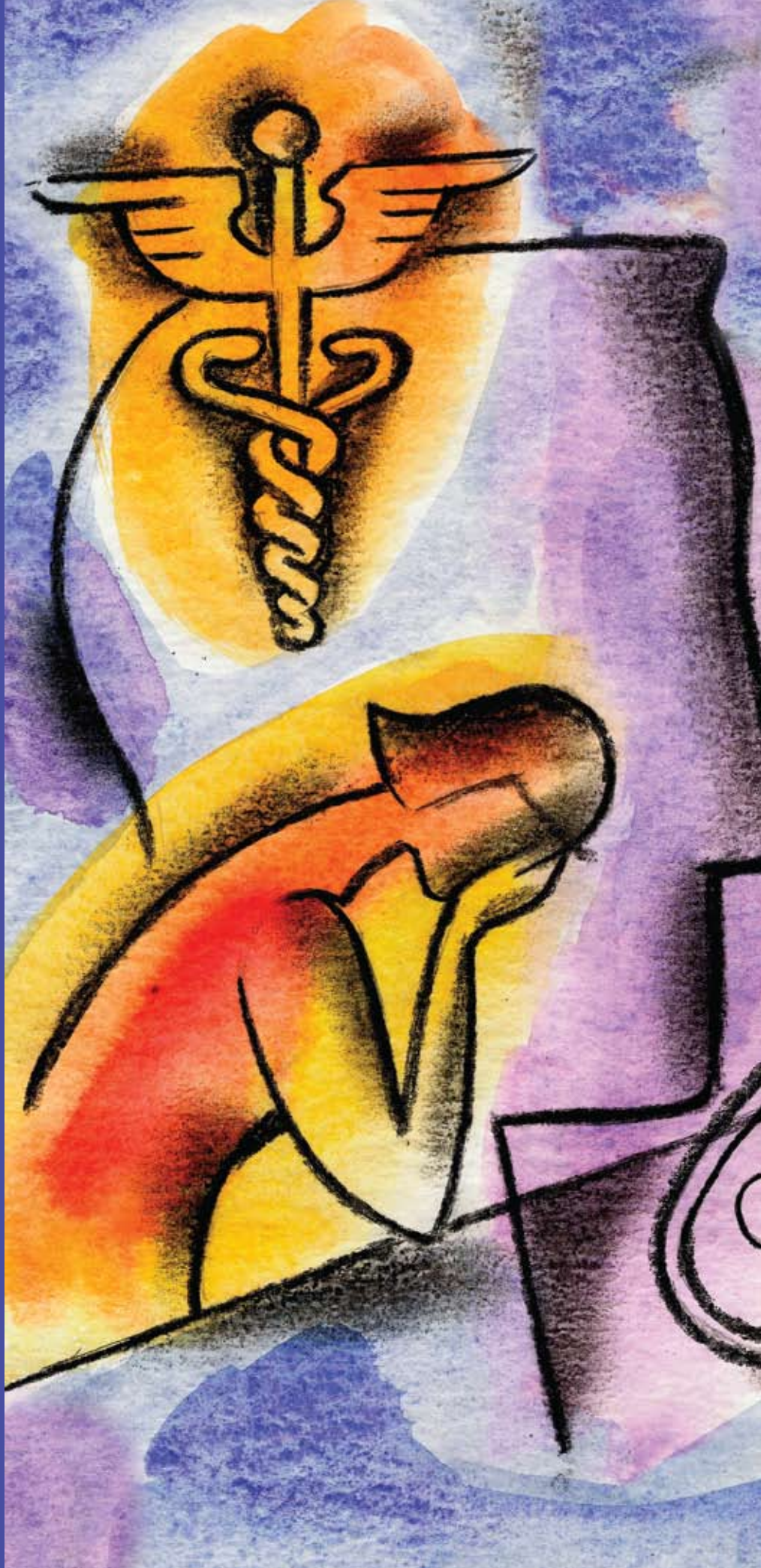


A Five-Step Plan for

ELIMINATING INEQUALITY IN HEALTH CARE

IN THE WINTER 2008 issue of Pathways, then–presidential candidate Barack Obama pledged to combat a health care crisis in America that disproportionately affects poor families and poor children. The larger economic crisis that has since taken hold might well have induced President Obama to shelve that commitment, but in fact he has reaffirmed that health care reform is integral to economic recovery. It follows that 2009 provides the first window of opportunity since Hillary Clinton's ill-fated reform in 1993 to fundamentally reshape our nation's health care delivery system.

BY KAREN DAVIS AND KRISTOF STREMIKIS



We argue here that any such reform must accomplish two goals: (1) promote efficiency and maximize overall health and (2) pay explicit and comprehensive attention to ameliorating health disparities. To date, there has been much discussion of how to make health delivery more efficient, while the issue of health disparities has been addressed principally through the narrow lens of universal coverage. We will argue that the goal of narrowing health disparities is very important for the nation and is unlikely to be achieved by focusing on universal coverage alone.

We will first review how the current health care system fails on both objectives: It is not only grossly inefficient but also generates gross disparities in health outcomes among racial and economic groups. We will then discuss why we should care about disparities, why disparities and efficiency are linked, and how efficiency might be increased and disparities reduced.

A Broken System

The performance of the current U.S. health care system is clearly suboptimal. We spend twice what other major industrialized nations spend on health care yet fail in providing health coverage for all. We rank 19th out of 19 advanced industrial countries on mortality that is amenable to medical care. In the last eight years, the uninsured population has grown 20 percent, and the number with inadequate insurance has jumped 60 percent. For all the vibrancy and innovation in our health care system, it is tragic that so many people find themselves unable to access even basic health care services.

Nowhere is the failure of our health system more evident than in the health outcomes of low-income and minority Americans, or in the quality of care they receive. Disparities are especially acute along racial and ethnic lines and extend across the health care continuum, including prevention, access to care, insurance coverage, quality of care, and mortality. Although these disparities are associated with poverty, education, stress, and the local environment, inequalities in health care access and health outcomes persist even after controlling for a host of non-medical determinants. Recent studies by the Commonwealth Fund, the U.S. Agency for Healthcare Research and Quality, and the Institute of Medicine have established the pervasiveness of the problem.

As documented in the Commonwealth Fund's recent report *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook,* minorities rate their health as poorer than whites, with African Americans most likely to report having a chronic illness or disability. African Americans also experience higher mortality rates from many cancers and diseases that are amenable to early diagnosis and treatment. For example, while non-Hispanic white women have the highest incidence of breast cancer, African American women have the highest breast cancer mortality rate.

Minority Americans have greater problems accessing high-quality health care than their white counterparts. Racial and ethnic disparities exist on key measures, including having a regular doctor or provider, having a usual place of health care, forgoing needed care, or forgoing dental care or prescription drugs. Minorities are less likely to receive timely access to care and are more likely to suffer conditions that may be caused by delays in care. With respect to effectiveness and efficiency, minorities have lower screening rates for preventable illnesses and are more likely to receive treatment in an emergency room when a primary care provider could have treated the condition. And in terms of safety, Asian Americans and Hispanics are more likely to die from complications during hospitalization than non-Hispanic whites. Finally, minority patients are more likely to report substandard communication with their provider—a problem exacerbated by language and cultural barriers. Clearly, any meaningful reform of the health care delivery system will need to address these widespread and systemic failures.

Why Disparities Matter

The case for caring about disparities rests on three arguments. First, one might treat disparities as self-evidently a problem, a tack that is implicitly taken by those who regard health or access to health care as an inalienable right. When the language of rights is invoked in this way, the claim is that health and health care are such fundamental resources that all citizens should be guaranteed at birth some minimal amount. This language implies that we should care about disparities not because they matter in and of themselves but because they mean that some are falling below a minimum threshold of health or health care. If the health of everyone were elevated by just enough to push even the least healthy person above that threshold, then the disparities that remain after that universal increase in health would by this logic be deemed unproblematic.

The second reason to care about disparities is that they are inconsistent with our shared commitment to equalizing opportunities for access to economic and non-economic goods. If some people are, by virtue of their race or class background, subjected to unhealthy environments and denied access to adequate health care, they are then disadvantaged in the competition for schooling, jobs, and good wages; and our commitment to equal opportunity for all, regardless of race or background, is not being upheld.

Third, even if one disregards any such commitments or values, one might still care about disparities solely because they are costly. It costs all of us money when the poor are denied preventive care, are obliged to resort to expensive emergency room treatment, or become sick because they cannot afford necessary drugs. It is in this sense that the twin objectives of efficiency and disparity-narrowing become one and the same. How, then, might a health policy agenda best redress such pervasive health inequality?

A Path Forward

Five strategies, if aggressively pursued by the Obama administration, show great promise for reducing these disparities. These strategies are: (1) extending affordable insurance coverage to all Americans; (2) reorganizing the health care delivery system to make it accessible and patient-centered; (3) providing financial incentives to improve care for all, and especially for underserved and at-risk populations; (4) raising benchmark levels of performance through investing in the infrastructure, information, and workforce required for high performance; and (5) providing leadership to achieve health care opportunity for all.

Providing affordable coverage for all: Health insurance for all is the major prerequisite for eliminating health care disparities and ensuring equal opportunity; in fact, insurance coverage is the single most important predictor of whether people obtain needed care. President Obama's health proposal would guarantee coverage for every child and make coverage affordable for all adults. His plan, which builds on our current mixed system of private and public health insurance, lets people retain their current coverage if they so choose. But it also makes new choices available for small businesses and individuals, including a public plan option, through a national health insurance exchange. According to estimates calculated for a similar proposal—the "Building Blocks" plan developed by Commonwealth Fund staff—annual family premiums could be lowered by $2,500 to $3,000 by taking advantage of Medicare's lower administrative cost and provider payment rates. Many of the 160 million Americans covered by employer plans would retain that coverage, and all employers except small businesses would be required to either provide coverage to workers or contribute to a fund to finance coverage. The State Children's Health Insurance Program (SCHIP) and Medicaid would be expanded to cover all low-income children and adults.

By building on what currently exists and works, the Obama health plan could quickly reach those most in need. Reauthorization and adequate funding of SCHIP would help about 6 million of 8 million uninsured children, including all children in families with incomes below three times the poverty rate. Letting young adults keep coverage under their parents' plans until age 26 would quickly reduce uninsured rates among the age group most at risk of going without coverage. Eliminating Medicare's two-year waiting period for the disabled and letting older adults buy in to Medicare before age 65 would close the gap in coverage for many disabled and chronically ill adults currently without access to affordable coverage. While achieving affordable coverage for all may take several years, quickly covering those most at risk would be an investment in future health and productivity and would help stimulate economic recovery.

Creating an accessible and patient-centered system: Eliminating health disparities will require reorganizing the health care delivery system to ensure that it is accessible, works for patients, and helps coordinate care in the face of complex problems. Ensuring access to a usual source of care and promulgating the "patient-centered medical home" would greatly reduce disparities among racial and socioeconomic groups. The patient-centered medical home model is one in which patients have access to a regular source of primary care, develop stable and ongoing relationships with a network of health care providers, and receive timely, well-organized health services that emphasize prevention and chronic care management. Enrolling the uninsured and low-income families in such clinics or physician practices would go a long way toward providing these vulnerable populations a point of entry into the health care system. The Commonwealth Fund Health Care Quality Survey found that when patients have a medical home, the racial and ethnic divide in access to needed care, preventive services, and control of chronic conditions closes. The Obama administration could immediately improve care for low-income and minority patients by converting all federally funded community health centers to medical homes and enrolling all Medicaid, SCHIP, and Medicare beneficiaries in practices that meet patient-centered medical home standards.

Reshaping payment incentives: Improving the health system's performance will require changing the way we pay for care. If we continue with current incentives, we will continue to receive inadequate care. The current method of paying physicians and hospitals largely rewards providing *more* care—especially complex, costly procedures. Three changes in the way we pay for care would begin to negate the perverse incentives that currently exist. First, clinics and physician practices meeting the standards of patient-centered medical homes should be paid a medical home fee that rewards providing accessible, coordinated care. This would enable both a team approach to care and the electronic information systems that can facilitate such care. A medical home payment could be supplementary to current fee-for-service arrangements, or it could cover all preventive and primary care for each enrolled patient.

A second fundamental shift would be to hold hospitals accountable for complications and transitional care upon discharge. By bundling payment for all services needed within 30 days of hospitalization into a global diagnostic case rate, hospitals would have a major incentive to ensure that patients do not reappear in emergency rooms for a condition that could have been prevented with appropriate information and follow-up care. In effect, this provides a "warranty" for hospital care. The Commonwealth Fund's state scorecard on health system performance found wide variations in the proportion of Medicare patients readmitted within 30 days, and its national scorecard on health system performance found that minority and low-income Americans are significantly more likely to experience potentially preventable hospital admissions for a host of conditions, including heart failure, diabetes, and pediatric asthma. The Medicare Payment Advisory Commission estimates that 75 percent of readmissions are avoidable. A global diagnostic case rate (with a warranty) would reward hospitals that provide excellent care.

A third payment reform would be to provide explicit rewards for results. Physicians and clinics that do a good job of managing diabetes or monitoring blood-thinning medications would receive "bonuses," as would hospitals with the best one-year survival rates for heart attacks or hip fractures, for example. Early evidence from demonstrations suggests that even if such bonuses are targeted to the top 20 percent of health care providers, they would serve as a powerful motivation for all to improve.

Investing in infrastructure, information, and the health workforce: Some providers serving low-income and minority patients are concerned they would be disadvantaged by such performance-based policies, since it is inherently more difficult to obtain the best results for patients who do not speak English, have limited education, or lack a family support structure. Undoubtedly, additional provider allowances would be needed to treat such patients. But rather than resist rewarding results, we must invest in the infrastructure, information, and workforce that would help safety-net clinics and hospitals meet high standards of care. In particular, funds should be made available to help safety-net providers adopt information technology and expand opportunities for minorities to train in the health professions and practice in underserved communities.

Investing in the promulgation of electronic medical records and health information technology will help bring coordinated care to underserved communities and reduce disparities in health outcomes. Commonwealth Fund studies have shown that advances in information technology make it easier for physicians to remind patients when preventive care is due, establish disease registries for monitoring appropriate care, prescribe and refill medications, and obtain information from specialists and hospitals on the care patients have received outside a primary care practice. Health plans and safety-net providers should, therefore, be encouraged to expand the use of electronic medical records through financial incentives, as well as clear standards and definitions for interoperable systems.

Ensuring the availability of well-trained, culturally competent health professionals will require adequate funding and expansion of workforce initiatives within the Depart-

It costs all of us money when the poor are denied preventive care, are obliged to resort to expensive emergency room treatment, or become sick because they cannot afford necessary drugs.

DENVER HEALTH: A High-Performance Public Health Care System

Denver Health, a comprehensive and integrated medical system that is Colorado's largest Medicaid and safety-net provider, is nationally regarded as a high-performance organization. According to a recent Commonwealth Fund case study, Denver Health has succeeded in providing coordinated care to traditionally underserved communities. The keys to Denver Health's success are (1) promoting a culture of continuous quality improvement, (2) building and using an innovative information technology infrastructure, and (3) training a culturally competent health care workforce sufficient for Colorado's expanding need. Moreover, Denver Health accomplishes its mission while remaining a fiscally sound leader in health care delivery.

Denver Health's investments in health information technology and workforce infrastructure are particularly noteworthy. Widespread use of electronic medical records allow patient information to be retrieved by providers across facilities, ease the production of patient reminders for needed preventive services and immunizations, and help providers safely and efficiently prescribe medication. Meanwhile, the organization exposes a new generation of health professionals to the benefits and rewards of practicing within an integrated delivery system capable of providing high-quality care to traditionally underserved populations. This, in turn, helps Denver Health develop a talent pool of clinicians trained to understand the challenges that are often faced by such populations.

ment of Health and Human Services. In particular, the health professions grant and loan programs under the umbrella of the department's Health Resources and Service Administration offer an especially effective avenue for meeting health workforce needs in shortage areas, increasing minority presence in health profession schools, and placing residency training in safety-net sites such as community health centers, public health agencies, and public hospitals. In establishing policy and funding priorities, senior leaders should focus on the need for an increased number of culturally competent medical graduates in a variety of specialties, especially in primary care disciplines.

Providing the leadership: Finally, the Obama administration should make it clear that eliminating racial and ethnic disparities in health care is a priority by providing the leadership required to achieve health care opportunity for all. By establishing and empowering a deputy assistant secretary for quality and disparities within the Department of Health and Human Services, the administration could bring high-level attention and resources to health disparities while reducing variation in quality along racial, socioeconomic, and geographic lines. Key first steps include requiring consistent data collection on race and ethnicity across federal programs; expanding funding, improving targeting, and setting performance goals for community health centers; and outlining a workforce policy that addresses the adequacy, diversity, and geographic dispersion of the primary care workforce.

This is an ambitious, but achievable, agenda. As a number of health and hospital systems have demonstrated, it is possible to increase access to care for vulnerable populations and transform hospitals and clinics into high-performing facilities. Ensuring that everyone has access to affordable insurance coverage, using the medical home model in health centers, clinics, and practices serving low-income communities, and improving the quality of care delivered by doctors and hospitals caring for minority patients are all proven strategies for providing Americans with an equal opportunity to lead healthy, productive lives.

As Robert F. Kennedy urged 40 years ago, the nation should have a better system of accounting for and measuring the benefits of investing in health care. President Obama should issue an annual report to Congress establishing health system goals, setting priorities for improvement, and monitoring the benefits, costs, and progress in maximizing health care spending value. Doing so would help the nation realize that health spending is not just a cost but an investment in the health of our people and the productivity of our economy.

Karen Davis, Ph.D., is the President of The Commonwealth Fund and a former deputy assistant secretary for health policy in the Department of Health and Human Services. Kristof Stremikis, M.P.P., is Research Associate to the President at The Commonwealth Fund.

EMPOWERING Individuals IN THE Health Care System

IT IS OBVIOUS that not all Americans enjoy equal access to affordable and high-quality health care. The problem is particularly acute for ethnic and racial minorities. In 2002, the Institute of Medicine of the National Academies of Science issued "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," which concluded that provider biases contributed to these disparities. Since then, there has been intensive examination of equality in access to quality care, provision of care in managed care, and the influence of socioeconomic and geographic factors correlated with race.

BY ROBERT E. MOFFIT

If the objective is to reduce disparities, and it should be, an important prerequisite is to get disadvantaged groups into the health care system. For example, Steven M. Asch and his colleagues recently found in their 2006 *New England Journal of Medicine* article that the usual economic and racial disparities in securing recommended care all but disappeared once patients made at least one visit to a health care provider. Another group of researchers led by Amal N. Trivedi, writing in a 2005 *New England Journal of Medicine* article, found that disparities between black and white *insured* patients declined in seven of nine recommended quality measures after they enrolled in Medicare-managed care plans.

The key factor, then, leading to persistent health disparities between demographic groups is access to the health care system. This article focuses for this reason on how the health care system may be improved in ways that will ameliorate disparities in health. Although there are, to be sure, other sources of disparities (e.g., residential segregation and consequent differential exposure to health risks), there is much room for reducing disparities through the health care system itself.

Health Insurance and Health Outcomes

A key variable is health insurance. The professional literature shows a positive relationship between health insurance coverage and health status. According to the National Academy of Sciences, health insurance is likely to improve patient outcomes if it is continuous and provides "appropriate" care, including preventive screening and drug coverage. Chronically ill persons with insurance coverage have better health outcomes than those without coverage, and persons who have had continuous coverage also have superior health relative to persons who have lost coverage or experienced a break in their coverage.

People without health insurance have less access to doctors, often delay medical treatment, lack continuity of care, and have worse health outcomes and higher rates of mortality than those who have it. In 2002, the Institute of Medicine estimated that 18,000 Americans died because they were uninsured. The number may be higher or lower in other years, but it is nonetheless significant. Because of their higher uninsurance rates, blacks and Hispanics are disproportionately affected by these problems.

The uninsured are more likely to resort to hospital emergency departments—the most expensive places on the planet—to secure even routine care. A study by Sally Satel of the American Enterprise Institute showed that quality of care is generally "comparable" for white and minority patients admitted for medical conditions requiring the same medical procedures. But the uninsured, *regardless of race or ethnicity*, are more likely than those with coverage to get substandard hospital care. And as the Heritage Foundation's John O'Shea has noted, Medicaid and SCHIP (State Children's Health Insurance Program) enrollees are *four* times more likely than persons with private health insurance to end up getting care in hospital emergency rooms.

Unequal Access

If access matters for health, then we should want to know whether access is highly unequal. The answer is that ethnic and racial disparities are especially pronounced in access to health insurance. Based on 2007 Census Bureau data, of the estimated 45.7 million Americans who are uninsured (15.3 percent), there are wide variations by race and ethnicity. While only 10.4 percent of non-Hispanic whites are uninsured, 19.5 percent of blacks and 32.1 percent of Hispanics are uninsured.

Recent Census findings confirm a familiar pattern that has persisted for many years. Overwhelmingly, white Americans have proportionately greater access to superior private and employer-based health insurance coverage, while blacks and Hispanics are more dependent on Medicaid, which has a record of inferior performance in the delivery of care. While only 9

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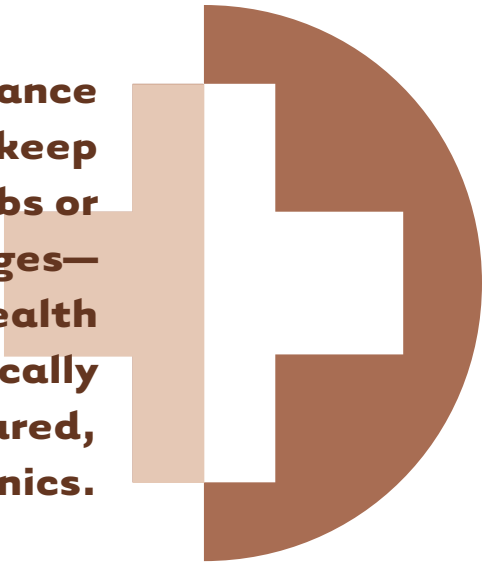

Portability of health insurance policies—enabling individuals to keep their coverage when they change jobs or maintain coverage through life changes—would be key to stabilizing health insurance markets and dramatically reducing the numbers of the uninsured, especially among blacks and Hispanics.

percent of non-Hispanic whites are on Medicaid, 23.8 percent of blacks and 22.5 percent of Hispanics are enrolled in the program. And according to analyses by Derek Hunter of the Heritage Foundation, restrictive Medicaid reimbursement practices have led to reduced access to physicians and specialists, as well as more restricted formularies for prescription medications. This has had direct—and decidedly negative—consequences for ethnic and racial minorities trapped in Medicaid.

Not surprisingly, blacks and Hispanics are also disproportionately dependent on hospital emergency room care, which is often uncompensated. In a 2004 New America Foundation study, researchers found that white hospital patients accounted for 55.7 percent of uncompensated care and 67.4 percent of the total population. Comparatively, blacks accounted for 17 percent of uncompensated care but just 12.8 percent of the population, while Hispanics accounted for 24.5 percent of uncompensated care but just 14.1 percent of the population.

As previously noted, insurance can be a great equalizer. According to the same New America study, when adults have health insurance coverage and a "medical home" (a setting that provides continued and coordinated care), ethnic and racial disparities in access and quality of care are reduced or even eliminated. Similarly, the National Academy of Sciences found that health insurance reduces disparities in the provision of hospital services, including services for cardiovascular conditions and trauma, to ethnic and racial minorities.

Gaps in Coverage

A rich fund of historical data shows that the uninsured are relatively young; overwhelmingly members of working families; disproportionately employed in small businesses that don't offer coverage; or working as part-time, seasonal, temporary, or contract employees. They are, as noted, disproportionately black and Hispanic. While some persons don't take advantage of coverage when it is offered to them at work (perhaps because they don't value it), most of the uninsured are not offered insurance at work, cannot afford it, or had it and lost it.

The vast majority of uninsured persons experience spells of uninsurance that usually last several months as they transition in and out of coverage, most often as a result of changes in their employment status. According to a seminal 2004 *Health Affairs* study based on four years of data on the uninsured, Pamela Farley Short and Deborah R. Graefe found that only 12 percent of the uninsured were without coverage for an entire four years; the rest had coverage and lost it, churning in and out of an unstable health insurance market.

Research also shows that instability in coverage is not confined to the private sector, either in the employer or the individual market; it also exists in government health programs, notably Medicaid, where eligibility changes with income or varies with administrative and regulatory changes. In fact, churning in Medicaid can be just as disruptive as churning in the private sector. In a 2005 Commonwealth Fund study of families and children over a two-year period, 30 percent of those who had initially enrolled in Medicaid experienced one or more spells of uninsurance.

Portability of health insurance policies—enabling individuals to keep their coverage when they change jobs or maintain coverage through life changes—would be key to stabilizing health insurance markets and dramatically reducing the numbers of the uninsured, especially among blacks and Hispanics.

Federal Change

There are federal and state policy options for tying health insurance to the person rather than the job, thereby making it dramatically more affordable. The key federal policy option is to change the federal tax treatment of health insurance. Today, the estimated $250 billion in federal tax breaks for health insurance is targeted not to individuals as *individuals*, but to individuals as *employees*, and only on the condition that they get health insurance through their place of work.

The generosity of existing tax breaks for health insurance cannot be overestimated, but they are regressive: The biggest tax benefits for health insurance go to upper-income workers who

need the least help. Workers who do not get health insurance through employers are denied generous tax benefits, and their coverage is thus less affordable than it would otherwise be; if they buy health insurance on the individual market, they may pay as much as 30 to 50 percent more in premiums for the same package of health benefits that would otherwise be available through an employer. Practically speaking, depending on the cost and condition of the insurance markets where they live, most middle-class persons without employment-based coverage cannot afford that extra financial burden; and for the working poor, especially Hispanics, this is simply unrealistic, forcing them to either go "bare" or depend on hospital emergency rooms or public programs.

Bipartisan Consensus

Senator Max Baucus (D-Mont.), chairman of the powerful Senate Finance Committee, notes that there is a broad bipartisan consensus among economists and policymakers that existing tax policy governing health insurance is inefficient and inequitable. Acknowledging technical differences in design among alternatives, Baucus has suggested a cap on the amount of health insurance premiums that can be excluded from taxation, while providing new subsidies for low-income persons to buy health insurance.

Senators Ron Wyden (D-Ore.) and Robert Bennett (R-Utah) have cosponsored major legislation (the Healthy Americans Act) that would repeal existing tax policy and replace it with a combination of new tax deductions and generous new subsidies for low-income persons to offset their insurance costs. Together, these financial changes would guarantee every person affordable health insurance coverage. During the 2008 presidential campaign, Senator John McCain (R-Ariz.) likewise proposed replacing the existing system with a universal refundable health care tax credit, specifying that the credit would be a flat dollar-amount credit for individuals and families and indexed to inflation.

The Lewin Group, a prominent Virginia econometrics firm, concluded during the campaign that McCain's flat credit would have been significantly more progressive than the existing system, resulting in millions of uninsured Americans securing coverage. Many economists, including conservatives like Stuart Butler and Edmund Haislmaier, have long favored a progressive credit that provides more help to low-income persons. Jason Furman, a Brookings Institution scholar and one of President Obama's key economic advisers, has also championed abolition of the current system in favor of a universal, progressive, and refundable health care tax credit, making the greatest level of tax and financial assistance available to middle- and lower-income uninsured persons who need the most help. The generosity of such a credit is an empirical issue. But, in any case, under any of these more progressive tax policies, uninsured blacks and Hispanics would benefit disproportionately from such a major policy change.

State Reform

While state officials obviously cannot change federal tax policy, they can make their health insurance markets more efficient, effective, and inclusive. The best way to do that is to create a statewide health insurance exchange, a key feature of the 2006 Massachusetts reform. If properly designed—*a very big if*—a statewide exchange can serve as a clearinghouse for information on all health plans available in the state. The exchange can then provide a mechanism to facilitate premium payments and the enrollment of employers and employees in the coverage plans of their personal choice. The exchange would also provide an administrator for government subsidies to help low-income persons get the health coverage of their choice, a large platform for intense market competition among numerous private insurers, and a way for both employers and employees to secure the generous benefits of existing federal tax law. A more detailed description of the function of a statewide health insurance exchange can be found on the Heritage Foundation's website.

An exchange can mitigate the existing restrictions of the federal tax code. If employers designate the exchange as their plan in fulfilling federal employment law requirements, any contribution they make to health plans chosen by their employees will be tax-free to the employer. Moreover, the value of the health benefits will be tax-free to the employee. Employers who don't contribute to employee health insurance can join the exchange and, as a condition of membership, set up Section 125 (tax-free) accounts from which employees can make tax-free premium payments for their chosen plans in the exchange.

This means that an employee can buy a health plan tax free and keep it as he or she moves from job to job. Personal and portable health insurance is a key benefit of the exchange. Portability is a powerful protection against being uninsured; continuity of coverage also ensures continuity of care, and thus better health care outcomes.

If a state allows *any* willing health plan to compete in the

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statewide exchange, allows Medicaid SCHIP enrollees to participate, and establishes a risk mechanism for coping with adverse selection, this can be a profoundly consequential health reform. It can sharply expand coverage and enable individuals and families to secure value for their health care dollars. It can also promote robust competition, patient-centered innovation, and productivity within the health care sector of the economy. Once again, blacks and Hispanics, especially those employed in small businesses, would benefit disproportionately from such an arrangement.

Genuine Diversity

These reforms should generate new types of care that are culturally competent and attuned to the very real differences in medical needs that exist among ethnic and racial minorities. The greatest opportunities for cultural competence in the delivery of health care rest with the culturally competent themselves in their own communities, not with pandering public officials in Washington clumsily clanking around in politically correct armor. If there is a level playing field in health insurance and individuals are empowered financially to buy the coverage that they want without today's onerous tax and regulatory penalties, the uninsured will be able to participate in very large group health arrangements outside of the comparatively small pools that exist today at places of work. This, too, would directly benefit ethnic and racial minorities.

With empowered patients, there is no earthly reason culturally competent health plans could not be officially sponsored, if not formally approved, by ethnic or fraternal societies, such as Hispanic organizations, or even by faith-based or religious groups, such as black churches, that are deeply rooted in their communities. Black churches, like the ethnic urban Catholic parishes a generation ago, are trusted institutions with a rich history of social and community service. New health plans, sponsored or approved by such institutions, could make available physicians and other medical professionals who speak languages other than English, and who have epidemiological expertise relevant to various ethnic or racial groups. The effect would be to reduce barriers to communication and enhance diagnosis and compliance with care recommendations.

New Options

These reforms would make new group insurance pools, completely outside of employment and sponsored by various private associations, increasingly common. In fact, literally thousands of such organizations for the delivery of insurance, including old age, disability, dismemberment, and sickness benefits, serving millions of Americans, including large numbers of the foreign-born, were active less than a century ago. In terms of membership and the value of their insurance reserves, some of these organizations were huge and, for their time, financially impressive.

According to *The Fraternal Insurance Compend* (1926), the Aid Association for Lutherans, which provided sickness and disability benefits, had 45,000 members with total insurance in

force worth $47 million, and the Polish Roman Catholic Union of America, which provided life and survivors benefits, had total insurance worth $61 million. Others were highly specialized, such as the Bohemian Roman Catholic Union of Texas, which provided life insurance for Texas males of Bohemian birth or descent. Others engaged directly in providing health care. The Taborites, a fiercely independent black fraternal organization, established hospitals during the early 20th century to ensure that black patients would get better care than they would in segregated Southern hospitals.

To recapitulate, the key to making health insurance affordable is (1) to change the federal tax code and retarget the hundreds of billions of dollars of tax assistance to individuals as individuals, rather than as mere employees, and (2) to redirect the tens of billions of dollars in existing federal and state government subsidies that go to institutions caring for the uninsured directly to the uninsured themselves—a new path taken by Massachusetts officials as part of their historic reform. More revenues might be necessary, but the retargeting of these large existing financial resources would help the uninsured get the coverage they want while simultaneously opening up health insurance markets to satisfy a diverse demand for quality health care.

If policymakers want to reduce ethnic and racial disparities in health care, they should get serious about empowering ethnic and racial minorities to secure superior private health insurance coverage and care and enabling them to escape the Medicaid ghetto. But it will take political imagination and a passion for serious innovation rather than merely filling "gaps" in conventional policies and old programs.

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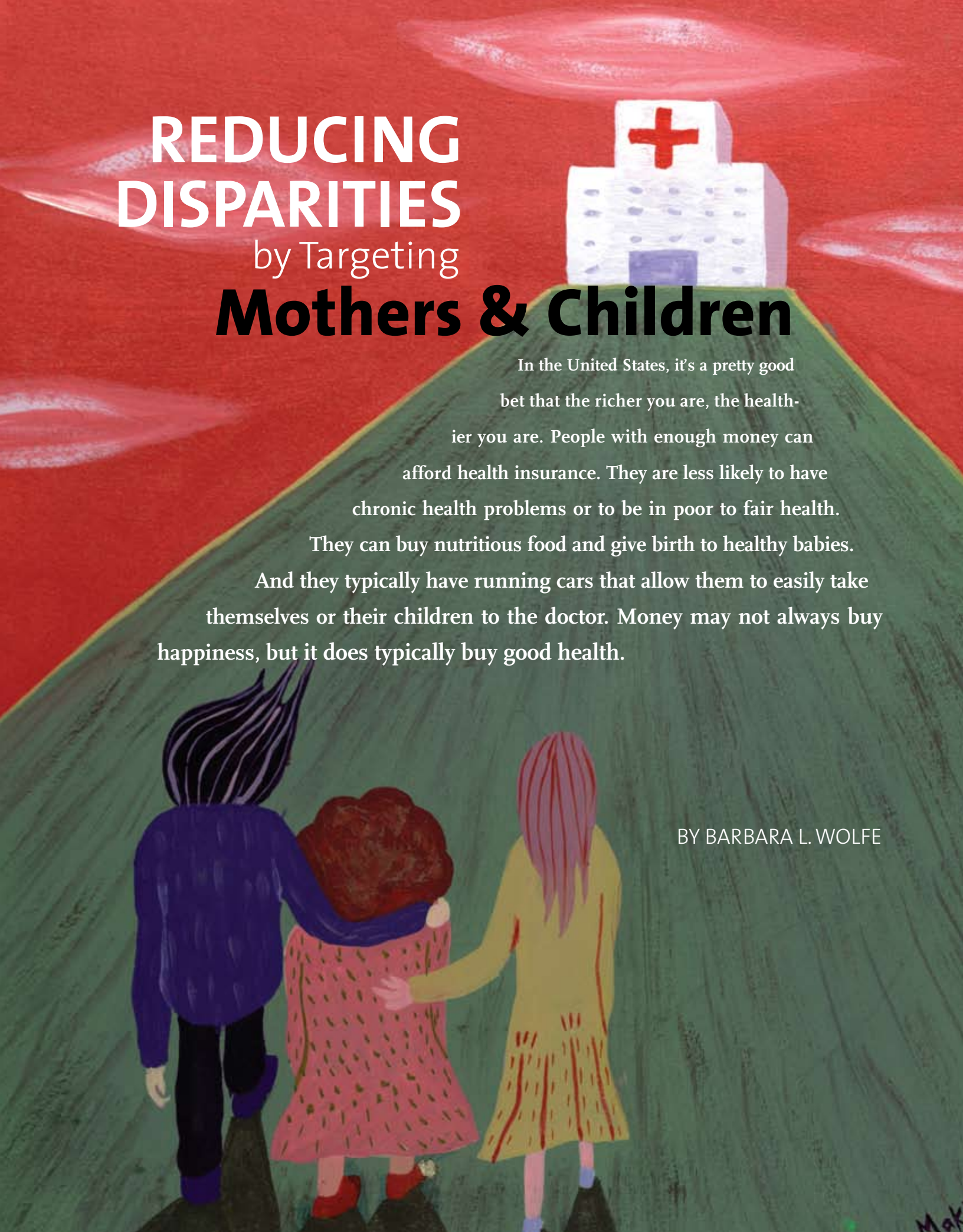
REDUCING DISPARITIES by Targeting Mothers & Children

In the United States, it's a pretty good bet that the richer you are, the healthier you are. People with enough money can afford health insurance. They are less likely to have chronic health problems or to be in poor to fair health. They can buy nutritious food and give birth to healthy babies. And they typically have running cars that allow them to easily take themselves or their children to the doctor. Money may not always buy happiness, but it does typically buy good health.



BY BARBARA L. WOLFE

A health disparity exists when a member of a racial or ethnic minority or a low-income person is in poorer health than he or she should be, given the individual's genetic makeup. Measurable health disparities are avoidable differences in health resulting from cumulative economic or social disadvantages.

Should we care about health disparities? It is obvious that disparities impose a cost on the individuals whose health falls short of what their genetic makeup would allow. For such individuals, suffering from chronic ailments or poor general health is not just an inconvenience; it additionally limits their ability to take advantage of economic opportunities and achieve some measure of mobility for themselves and their families.

It is perhaps less obvious that health disparities also harm those who are in good health by reducing the population's overall economic productivity and by creating societal burdens that are borne by all, such as excessive medical use for treatable conditions, including avoidable hospital stays. It follows that health disparities weaken economic productivity for both individuals and society as a whole. They lead to lower productivity in the home and the labor market, to less personal well-being, and to the continuance of health and income disparities in future generations. For the long-term economic health of our nation, we need a public policy that advances the physical and mental health of all our people, regardless of income, race, or ethnicity. As the United States turns again to health care reform, we would do well to review the sources of these disparities, to identify how policy might best reduce them, and to shape reform accordingly.

In the remainder of this article, I lay out some preliminary arguments for how we might accomplish this. But first I discuss in more detail how poverty impacts childhood health, as the payoff to reducing disparities in childhood health is especially large. An investment in childhood health can reap substantial benefits over an individual's entire life. Although one might alternatively make the same-sized investment in the health of an 80-year-old, such an investment will extend that person's life by less, increase her or his economic productivity by less, and reduce pain and suffering for a shorter period of time.

Disparities and Childhood Poverty

Almost one-third of children ages 2 to 17 living in poor families have a chronic health condition, compared with 26.5 percent of children in nonpoor families, according to a recent national study by Janet Currie and Wanchuan Lin. Poor children are more likely to be diagnosed with mental conditions such as learning disabilities, developmental delays, Down syndrome, and autism. Seventy percent of poor children's mothers report that their children are in very good or excellent health, while 86.9 percent of wealthier children's mothers report such good or excellent health.

Health disparities are also evident in life expectancy and mortality rates. Angus Deaton, using the National Longitudinal Mortality Study, shows that people in families with yearly incomes (in 1980 dollars) lower than $5,000 had a life expectancy about 25 percent lower than that of people with family incomes greater than $50,000.

Poor health has important implications for children's futures. Poor health at birth, coupled with limited family income and health insurance, "can interfere with cognitive development and health capital in childhood, reduce educational attainment, and lead to worse labor market and health outcomes in adulthood," according to a recent study by Rucker Johnson and Robert Schoeni. The same study also finds that "low birth weight ages people in their 30s and 40s by 12 years, increases the probability of dropping out of high school by one-third, lowers labor force participation by 5 percentage points, and reduces labor market earnings by roughly 15 percent."

While somewhat controversial, research by Anne Case, Darren Lubotsky, and Chris Paxton provides evidence that, as children age, the negative effects of poverty on health only increase. Janet Currie and Mark Stabile ask whether this is because children in poor homes are more exposed to health risks or because they do not have adequate access to medical care. If it is the latter, then expanding coverage should reduce the observed gradient. Using data from Canada, a country with universal health insurance, Currie and Stabile find a similar pattern of steeper health gradients as children age, which suggests that the problem is one of greater exposure to health shocks among low-income children. These disparities are unlikely to be significantly reduced through universal coverage focused narrowly on access to medical care.

A Broader View

I propose a five-pronged approach to reducing disparities that is informed by two principles: (1) it is cost-effective to concentrate our scarce resources on reducing disparities in the health of children, and (2) it will not prove possible to make substantial headway in reducing disparities among children and their parents by simply equalizing access to medical care. The resulting broad-based reform should focus on five tactics: improving

The health reform agenda of the 21st century should be based on two principles: a recognition of the payoff of early intervention, and a recognition that universal coverage alone is not adequate to the task of reducing disparities.

the nutrition of pregnant women, expanding visiting nurse programs, subsidizing transportation costs to help poor people get to doctors, creating incentives for health care providers to practice in low-income areas, and improving communication between health care professionals and their patients. These specific reforms, coupled with universal health insurance, would go a long way toward reducing health disparities.

Early Intervention

President Barack Obama's health reform agenda has not been brought fully into correspondence with his antipoverty agenda. Whereas his antipoverty initiatives are built explicitly around the increasing consensus that early intervention programs create a high payoff, his health reform policies have not embraced the equally compelling argument on behalf of early-intervention health care programs. The following two early-intervention programs promise substantial benefits at a very reasonable cost.

Prenatal nutrition: Evidence increasingly shows that pregnancy is the time when health-related investments can yield large payoffs, both in the near and long term. One major problem is low birth weight. A 1991 study by Barbara Starfield and colleagues finds widespread prevalence of low birth weight among the poor, especially the chronically poor. Using national data, Sanders Korenman and Jane Miller have also shown that children are more likely to be stunted, or have low height for their age, if they grow up in poor homes. According to David Barker, pregnant women lacking good nutrition have children that are especially vulnerable to these poor outcomes. Lack of nutrition, especially late in the pregnancy, is linked to kidney malfunction and type 2 diabetes. Low birth weight, especially for those born full term, is associated with increased risks of adult hypertension. Although subsequent evidence is mixed, Barker argues that lack of nutrition in utero correlates to a greater incidence of disease among humans. And evidence from the Dutch famine (Ravelli, et al 1998) is fully consistent with the importance of in utero nutrition for adult health outcomes.

Poor prenatal nutrition (in addition to other factors like stress and pollution) is also a leading factor behind America's still alarmingly high infant mortality rate. The United States ranks 41st in the world in infant mortality, behind such countries as Sweden, Spain, the Czech Republic, Israel, and Cuba. Moreover, infant mortality differs substantially by race. Among non-Hispanic black women in 2008, the mortality rate was 2.4 times that of non-Hispanic white women, according to the U.S. Centers for Disease Control and Prevention. The Kaiser Foundation finds that America's infant mortality rate continues to be high even though Medicaid finances a large percentage of births. Given that many of these women were uninsured prior to learning of their pregnancies, providing medical insurance to women only when they become pregnant does not seem to sufficiently reduce our infant mortality rate. Reform must also seek ways to increase women's access to health care and try to influence the behavior of pregnant women, including improving nutrition, in order to improve infants' life chances. Opening more community centers that offer information on healthy lifestyles, family planning information, and access to medical providers in low-income areas could help influence the health-related choices of women of child-bearing age.

Visiting nurse programs: Visiting nurse programs have consistently shown promise in improving health outcomes for vulnerable populations who suffer from health deficits. The Nurse Family Partnership, for example, has systematically improved prenatal care and infants' health and caretaking. This program, underway in several U.S. cities, assigns nurses to visit the homes of disadvantaged women who are new mothers or pregnant. When program evaluators followed up with families 15 years after they began the program, they found that children whose families received visiting nurses reported fewer arrests, convictions, and violations of probation. Moreover, children whose families received visiting nurses reported fewer sexual partners, lower rates of cigarette smoking, and fewer days of alcohol consumption. The poorest families showed the

greatest benefits across most outcomes. These results suggest that including visiting nurses as a component of public health care coverage for low-income mothers not only improves health but also has spinoff benefits.

Improving Access

If access to health insurance were broadened, health disparities would undoubtedly be reduced. For example, Jack Hadley's extensive 2003 review finds that low-income persons with hypertension did not fare well when they lost their insurance or faced extensive cost sharing (e.g., were required to pay 20 to 35 percent of all charges or had to pay a $1,000 deductible). Similarly, people lacking health insurance who have acute myocardial infarctions are more likely to die than those who have insurance. And uninsured people with cancer are more likely to be diagnosed at a later stage in the disease and have higher relative mortality rates.

But simply having insurance is not enough. If poor people cannot get to their doctors, do not have doctors willing to work with them in their communities, do not receive cost-effective preventive care, or have difficulties communicating with their health professionals, then their health will continue to suffer relative to their more advantaged peers. The following three reforms, all simple and cost-effective, would address these problems.

Bringing poor people to doctors: One major problem perpetuating health disparities is transportation costs. Low-income people with treatable health problems are less likely to acquire useful medical care because of problems getting to physicians and medical centers. This is also likely to be true for preventive care. If low-income people are reluctant to get care because transportation is costly or cumbersome, they are far more likely to delay or avoid acquiring such care. It would therefore be good policy to simply cover the costs of transportation for certain low-income persons, especially those with special transportation needs. Otherwise, these individuals may not seek care as they find that the cost of transportation is higher than their willingness to pay, given their other basic needs. This is very much the case of a cheap, simple, and obvious reform yielding large dividends.

Bringing doctors to poor people: It would be helpful to improve incentives for providers to practice in distressed areas. Research shows that medical providers continue to eschew practicing in low-income areas because of more lucrative opportunities in specialist fields and higher-income areas. If providers prefer practicing in higher-income areas, then low-income and low-income minority areas will continue to face provider shortages and continue to be underserved. By shortages, I mean situations where effective demand cannot be met or where there are long delays in obtaining care, not simply a shortage defined by a ratio of providers to population. It would be good policy to simply pay providers more to practice in low-income or less desirable areas. If providers could be lured into practicing in areas where they are needed most, this would go a long way toward ameliorating disparities tied to race and income.

Improving provider-patient communication: Even if low-income people can find easy and affordable transportation to providers, or have more providers in their communities, there remains the problem of provider-patient communication. This problem is seemingly difficult to solve: Doctors may have difficulty fully understanding the dietary constraints, cultural mores, language, and symptoms of our country's most vulnerable people. A straightforward solution is to supplement the work of doctors with trained and competent providers who would follow up with patients and encourage better compliance with prescribed care. Considering the success of visiting nurse programs, as well as other programs that use community support personnel, tapping pools of people with suitable communication skills could help fill the communication gap. Critics might well argue that spending resources on addressing communication gaps might be too costly. Such investments, however, pale in comparison with the short- and long-term costs of inappropriate or ineffective care, not to mention the resulting loss of productivity.

The Next Agenda

The health reform agenda of the 21st century should be based on two principles: a recognition of the payoff of early intervention, and a recognition that universal coverage alone is not adequate to the task of reducing disparities. These are, to be sure, simple principles, but they are ones that will nonetheless serve us well. We need results, not just more insurance.

This is not to gainsay the equally important point that universal coverage is desperately needed. It would go some way toward improving medical care and reducing health disparities. But we would be naïve to think that universal coverage, in and of itself, will solve the pervasive and persistent health disparities that are weighing down American productivity and equality of opportunity.

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Transforming the EITC to Reduce Poverty and Inequality

Policies for the 21st-Century Labor Market

BY GORDON BERLIN

While we now know much more than we once did about what reduces poverty, we may no longer have the financial resources to use this knowledge given the current economic crisis and a gloomy budgetary outlook. Nevertheless, even as we struggle to stimulate a very troubled economy in the near term and to tackle rising unemployment, it is important to see beyond the current crisis to address the underlying causes of persistent poverty and chart a long-term course.

I argue in this article that the 35-year decline in average earnings played a causal role in both poverty's persistence and rising inequality, and I make the case for a radical change in policy: (1) retaining the current family-based federal Earned Income Tax Credit (EITC), (2) replacing the existing (and tiny) $428 EITC for singles without children with a significantly more generous credit—up to a maximum of $2,000, and (3) eliminating all marriage penalties in both the existing credit and this new credit for singles. These changes would go a long way toward reducing poverty and income inequality for the lowest earners and restoring equity to the American social compact for single men and women, as well as for childless couples. It would also minimize the distortion of incentives to work, marry, cohabit, and bear and support children.

What's Behind Persistent Poverty?

While the U.S. poverty rate has remained virtually unchanged for 35 years, total economic growth (as measured by gross domestic product) has tripled over the same period (see Figure 1). So why didn't this economic growth reduce poverty? There are four principal explanations: (1) the returns to economic growth, which used to be shared with the bottom half of the income distribution, are now accruing primarily to the top 1 percent; (2) the three-decade stall in inflation-adjusted average wages and earnings has had particularly devastating effects on workers with a high school diploma or less; (3) employment rates among men, particularly teenagers, have declined precipitously, as have rates of full-year, full-time work; and (4) single-parent households are increasingly common, a result of the 40-year upward trend in divorce and a 30-year increase in out-of-wedlock childbearing.

Reversing the long-term secular decline in earnings is key to addressing the nation's persistent poverty problem. From 1947 to 1973, real average earnings grew steadily at 2 to 3 percent per year. In this period, economic growth benefited those at the bottom of the income distribution; today those benefits accrue entirely to the top 1 percent. Why? Globalization and technological change placed a new premium on higher education (particularly in the 1980s and 1990s), while immigration placed new pressure on wages at the bottom of the earnings distribution. As economists Frank Levy and Peter Temin have described, these macroeconomic forces were exacerbated by the decline in unions, in the minimum wage, in tax rates on the wealthy, and in norms governing CEO pay—institutional structures that had helped low-wage workers in the mid-20th century. A new set of 21st-century labor market institutions have yet to replace and reconfigure these currently moribund institutions and polices.

The persistence of stagnant earnings has a cascading effect on a cluster of poverty-related problems. The interactions between low earnings, reduced employment, increased incarceration, and nonmarital childbearing have created a tangled web of reinforcing social conditions. For example, low earnings and single parenthood interact to exacerbate poverty and inequality. Single-parent families are more likely to be poor than two-parent families—five times more likely—in part because these families are more likely to have low education levels and command low wages, and in part because they have only one earner when most two-parent families have two.

What Is the Best Fix?

To make progress against poverty and inequality in America, we must do something about stagnating and falling earnings—that is, we must once again make work pay for the bottom half of workers. This is exactly what we have begun to do with the Earned Income Tax Credit (EITC)—by far the nation's largest antipoverty program, accounting for $47 billion a year in federal expenditures. Conditioned on work, the EITC is a safety net built around employment—only people with earnings from gainful employment can claim the credit. The value of the EITC varies by both family type and annual earnings. Families with two or more children can receive a maximum annual credit of $4,716; those with one child, $2,853; and single adults with no children, $428.

The credit therefore virtually ignores an entire class of workers: those who are not supporting children. The U.S. social welfare system was designed almost exclusively to meet the needs of poor families with children, a majority of whom are now female-headed, single-parent households. Outside of food stamps, few work supports are available for childless individuals; indeed, the only public systems that focus predominantly on able-bodied men who are not living with children are criminal justice and child support enforcement. Adding insult to injury, by treating income jointly, the tax system penalizes some couples when they do marry, especially couples who earn like amounts and have combined annual earnings between $20,000 and $30,000. As they begin to lose eligibility for food stamps and health benefits, such as Medicaid and the State Children's Health Insurance Pro-

gram, and cross over to the phase-down range of the EITC, they can lose as much as a dollar in benefits for every dollar increase in income. In a vicious cycle, once they are married, the same high cumulative marginal tax rates penalize additional work effort, a clear deterrent to work by the second earner. An unintended consequence of this policy choice is a distortion of incentives to work, marry, cohabit, and bear and support children.

Do Earnings Supplements, Like the EITC, Work?

A strong and reliable body of evidence indicates that earnings supplements, like the EITC, do much good. Nonexperimental evidence suggests that the EITC increases work, increases income, reduces family poverty by a tenth, and reduces poverty among children by a fourth. Remember that the Census Bureau's official poverty estimate doesn't count the EITC as income; if it did—and if one also subtracted the cost of work expenses, child care, and payroll taxes—the poverty rate would likely fall by a couple of percentage points.

This research is buttressed by results from the "make work pay" experiments. Concerned that low-wage work simply did not pay relative to welfare, the state of Minnesota, the New Hope community group in Milwaukee, and two provinces in Canada began testing new approaches to increase the payoff from low-wage work in the 1990s—that is, to make work pay. All three combined work-conditioned incentives in the form of monthly cash payments to supplement the earnings of low-wage workers. The payments were made only when people worked, and the amount of each month's cash payment depended on the amount of each month's earnings. The mostly single mothers who were offered earnings supplements in these three large-scale, rigorous studies were more likely to work, brought home more earnings and income, and were less likely to be in poverty than control group members who were not offered supplements. At their peak, these employment, earnings, and income gains were large—reaching 12 to 14 percentage point increases in employment rates, $200 to $300 more in quarterly earnings, and $300 to $500 more in quarterly income. While overall earnings effects dissipated over time, large and persistent effects were found for African-Americans and for the most disadvantaged participants, particularly high school dropouts without a recent work history and with long welfare spells. Unexpectedly, parents' employment and income gains produced, in turn, modest but important improvements for their younger school age children in a range of school measures, including standardized test scores.

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An Enhanced EITC for Singles and Second-Earners, with a Radical Twist in Tax Policy

If the evidence suggests, then, that an expanded EITC could further reduce poverty and inequality, how might we undertake such an expansion? There are many relevant proposals. These include enhancing the generosity of the basic family-based EITC benefit, increasing it for married couples only, boosting it for large families (currently, a two-child family receives the same benefit as a family with more children), and expanding the benefit for noncustodial parents when they pay child support. While each of these plans would reduce poverty, they have the disadvantage of perpetuating or exacerbating current inequities. In the remainder of this article, I outline a bold plan to revamp the EITC for the 21st-century labor market—establishing a new EITC for singles and second-earners. It has the virtue of being *simple* to understand, *generous* enough to stimulate a behavioral response, *neutral* (with regard to incentives to work, marry, and care for children), and *equitable* by reducing inequalities between adults with children and those not raising children—four criteria any EITC expansion plan should be judged against.

This plan to transform the nation's work-based safety net would (1) retain the current family-based EITC, (2) replace the existing $428 EITC for singles without children with a significantly more generous credit—up to a maximum credit amount of $2,000, and (3) eliminate all marriage penalties in both the existing credit and this new credit for singles by basing eligibility on individual rather than joint income.

The enhanced EITC would make work pay for singles without children *and* for second-earners in two-parent families currently receiving the existing family-based EITC. In the latter families, the primary earner would continue to qualify for the child-based EITC, with the actual benefit amount based on his or her individual earnings. But now the second earner would qualify for a separate credit for singles. Such a change seems radical at first blush, considering the way the United States treats income for tax purposes. In Canada and some European countries, however, taxes are based on individual rather than family income, so there is precedent and experience on which to base operational details.

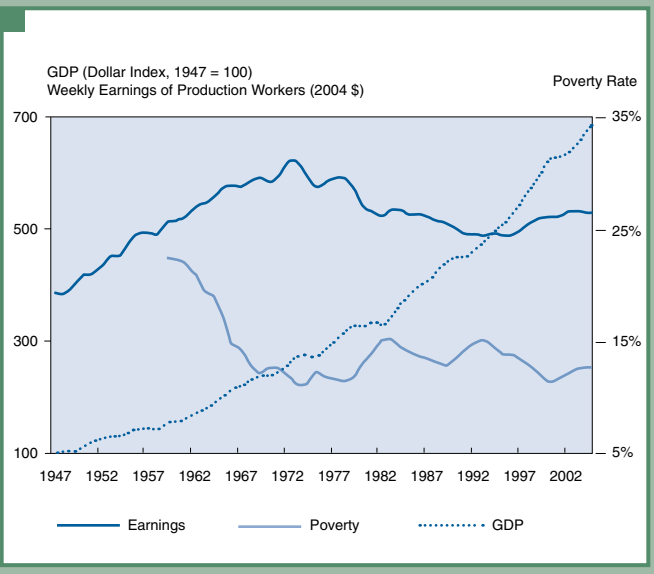
Consider Jack and Jill. Jack works full time (2,000 hours per year) at $7.25 an hour—earning $14,500 a year. His income exceeds the $12,590 eligibility for the current EITC credit for singles. However, under the new singles benefit, he would receive an EITC refund check from the IRS totaling $2,000, or a 14 percent increase in his income. In other words, his $7.25-an-hour job now pays $8.25 an hour. Jill works for the same company, holds a similar job, and receives the same pay—$14,500 a year.

As a single parent with two children, she qualifies for the existing family-based EITC and, at the end of the year, receives a tax refund payment of $4,710, bringing her total annual income to $19,210. With the help of the EITC, Jill's $7.25-an-hour job now pays $9.60 an hour.

Assume for a moment that Jack and Jill head up the hill to fetch a marriage license. Under current law, their joint income would equal $29,000, and Jill's EITC refund payment would fall to $2,260, a marriage penalty of $2,450. Now consider their life together in a world where singles qualified for a more generous credit and where both the singles credit and the family credit were based on individual income, not joint income—a world without marriage penalties. Jack would receive a singles credit of $2,000 and Jill the existing family credit of $4,710, for a combined amount of $6,710 and a total family income of $35,710.[1]

To avoid unintended consequences, policymakers should consider taking three additional, complementary actions. First, because the EITC is adjusted for inflation, it might be wise to also index the minimum wage to inflation, to avoid substituting future EITC increases for private wage increases. Second, to limit the likelihood that current full-time workers might reduce their work effort, and to encourage the unemployed or underemployed to work full time, one could limit the new singles supplement to people who work an average of at least 30 hours a week. Third, to avoid windfalls to otherwise well-off families, an arbitrary eligibility cap might be imposed on families with joint income that exceeded $65,000.

FIGURE 1. Trends in Earnings, Poverty, and GDP 1947–2004



Sources: Bureau of Labor Statistics, U.S. Census Bureau, U.S. Dept of Commerce. Note: The Gross Domestic Product is represented as an index in which its 1947 value is $100 — the line shows that the GDP grew sevenfold between 1947 and 2004 (after taking inflation into account).

But Would It Actually Work?

The impact on poverty of this enhanced EITC would be certain, large, and immediate. Individuals who now work more than 30 hours a week (assuming a full-time work requirement) and earn less than the threshold amount annually (whether married, cohabiting, or unattached) would receive an immediate supplement. This supplement would help restore their earnings toward pre-1973 levels, when the average high school graduate—or even high school dropout—could support a family above the poverty line. Those working less than 30 hours a week, including second-earners in two-parent households, would have an incentive to increase their work hours, further boosting income, promoting self-sufficiency, and reducing poverty. Finally, those not in the labor force would have added incentive to find a full-time job, even if it offers low pay.

Reliable experimental evidence indicates that revamping the EITC in this way would yield substantial employment gains. Economists estimate that increasing the hourly wage of low-income workers by 10 percent would boost employment between 2 and 10 percent. Adding credence to these estimates, the three "make work pay" experiments described above had similar employment, earnings, and income effects, albeit for a population of mostly single mothers.

Less reliable observational evidence suggests that an enhanced EITC could also have small but significant beneficial effects on crime and marriage. As earnings rise, so do the opportunity costs of engaging in crime, meaning that men's involvement in criminal activity might reasonably be expected to decline. Similarly, higher earnings, together with the elimination of EITC-related tax-and-transfer penalties on marriage, might also lead to more coparenting, cohabitation, and marriage. Although these secondary effects are speculative, an individually-based EITC benefit at least creates the necessary, if not sufficient, conditions to make an increase in marriage feasible.

Finally, by supplementing the earnings of single men in low-wage jobs and increasing income, this plan encourages more "on the books" work, which would help men meet their child support obligations. As with current law, singles who are parents and owe child support would receive their EITC payment contingent on paying their child support obligations.

Would It Be Worth the Cost?

A generous EITC for singles without marriage penalties would cost roughly $33 billion a year. To put that number in perspective, this represents about a third of the annual tax reduction received by the top 1 percent of tax filers as a result of the Jobs and Growth Tax Relief Reconciliation Act of 2003. It is also equal to about 4 percent of the extra $750 billion in annual income that Steven

Pearlstein of the *Washington Post* estimated now accrues to the top 10 percent of earners as a result of changes in the income distribution since the early 1970s. In return for this investment, poverty among singles and two-parent households would *surely* decline. And, as noted above, it is also possible we might see salutary secondary effects of increased employment, reduced crime, and rising marriage and cohabitation rates. In some cases, these secondary effects could generate state and federal savings, most notably in the form of reduced incarceration costs.

An enhanced EITC for individuals without marriage penalties would effectively end poverty today for individuals and families who are able to work full time. . .

Encouragingly, policy consensus is growing around the need to raise men's earnings, and a bevy of experts and political leaders support increasing the EITC for singles as a mechanism: New York City Mayor Michael Bloomberg; Congressman Charles Rangel, chair of the powerful House Ways and Means Committee; neo-conservatives like Ross Douthat and Reihan Salam; major think tanks, including the Progressive Policy Institute and the Center for American Progress; and leading academics, including Harry Holzer, former chief economist at the Department of Labor, John Karl Scholz at the University of Wisconsin, and Gene Steuerle of the Peter G. Peterson Foundation.

In the current environment of economic and budget crises, a generous expansion of the EITC for singles, coupled with elimination of marriage penalties, may not be regarded as feasible. However, insofar as deficit-expanding stimulus is to be undertaken, there are good reasons to make an enhanced EITC part of that stimulus, providing an opportunity to test the effects of a more generous singles EITC than might otherwise be possible. By delivering extra income to the bottom of the income distribution, the increased EITC would direct stimulus toward that subpopulation that is most likely to spend it, thereby increasing the multiplier effect, while also yielding crucial evidence to guide future policymaking in this area. To be effective stimulus, however, an expanded EITC should be paid quarterly rather than annually, as is the case now.

At minimum, a prudent next step is to proceed incrementally—for instance, increasing the existing single credit modestly, as Congressman Rangel has proposed, and reducing marriage penalties somewhat—while mounting a rigorous demonstration and evaluation of a more generous program in one or two locations, perhaps with stimulus funding. Key questions the demonstration could answer include: What is the take-up rate for this revamped EITC? Does the offer draw people who are not working into the labor market? Does it reduce job-leaving? Do full-time workers cut back their work effort? How does it help two-parent families? What impact does it have on men versus women? What impact does it have on marriage and child-bearing? What is the effect on criminal involvement?

If a fundamental revamping of EITC isn't feasible now, a scaled-back approach of this sort allows us to move forward with our historic experiment in "making work pay"—because any serious effort to address income inequality and poverty will have to tackle nearly four decades of stagnant and falling wages, particularly for single men. An enhanced EITC for individuals without marriage penalties would effectively end poverty today for individuals and families who are able to work full time, while minimizing the distortions in incentives to work, coparent, and marry that exacerbate poverty and its persistence.

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NOTES

1. How would the credit for singles and second-earners work? In "EITC speak," every dollar in earnings would be supplemented by 25 cents until total annual earnings reached $7,800 and a maximum credit amount of nearly $2,000. At that point, the supplement would remain level until earnings reached nearly $14,500, when it would then fall to 16 cents for every additional dollar of earnings until it is phased out entirely at roughly $26,600. This compares with a 40 percent phase-up rate in the family EITC, a maximum credit amount of $4,716 paid when earnings range between $11,790 and $15,390, and a phase-down rate of 21 percent with payments ending when earnings reach $37,783. Under the new plan proposed here, married individuals would continue to receive EITC payments until their joint income reached $64,383, although the actual dollar amounts paid out for couples earning $50,000 and above would be very small. Remember that the child tax credit is paid until adjusted gross income reaches $115,000 and that there is no income limit on the dependent exemption.