How did the Brazilians do it? One key factor was a new program known as *Bolsa Familia* (family grant). This program—modeled on a similar program in Mexico, but carried out on an even larger scale—offers what are known as "conditional cash transfers": payments that are available to poor families provided they meet certain requirements designed to help break the cycle of poverty. In particular, to get their allowances, families must keep their children in school and go for regular medical checkups, and mothers must attend workshops on subjects such as nutrition and disease prevention. The payments go to women rather than men because they are the most likely to spend the money on their families.

As of 2010, Bolsa Familia covered 50 million Brazilians, a quarter of the population. The payments don't sound like much by U.S. standards: a monthly stipend of about $13 to poor families for each child age 15 or younger attending school, slightly higher payments for older children still in school, and a basic benefit of about $40 for families in extreme poverty. But Brazil's poor are very poor indeed, and these sums were enough to make a huge difference in their incomes.

The success of Bolsa Familia has led to the establishment of similar programs in many countries, including the United States: a small pilot program along similar lines has been established in New York City.

- **Means-tested** programs are designed to reduce poverty, but non-means-tested programs do so as well. Programs are classified according to whether they provide monetary or **in-kind benefits.**
- "Welfare," now known as TANF, is far less generous today than a generation ago due to concerns about its effect on incentives to work and family breakup. The **negative income tax** addresses these concerns: it supplements the incomes of only low-income working families.
- Social Security, the largest program in the U.S. welfare state, is a non-means-tested program that provides retirement income for the elderly. It provides a significant share of the income of most elderly Americans. Unemployment insurance is also a key social insurance program that is not means-tested.
- Overall, the American welfare state is redistributive. It increases the share of income going to the poorest 80% while reducing the share going to the richest 20%.

CHECK YOUR UNDERSTANDING 18-2

1. Explain how the negative income tax avoids the disincentive to work that characterizes poverty programs that simply give benefits based on low income.
2. According to Table 18-4, what effect does the U.S. welfare state have on the overall poverty rate? On the poverty rate for those aged 65 and over?

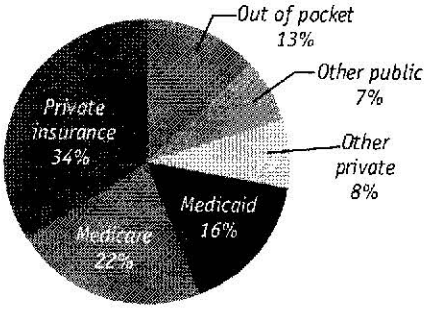
Solutions appear at back of book.

The Economics of Health Care

large part of the welfare state, in both the United States and other wealthy countries, is devoted to paying for health care. In most wealthy countries, the government pays between 70% and 80% of all medical costs. The private sector plays a larger role in the U.S. health care system. Yet even in America the government pays almost half of all health care costs; furthermore, it indirectly subsidizes private health insurance through the federal tax code.

Figure 18-5 shows who paid for U.S. health care in 2009. Only 13% of health care consumption spending (that is, all spending on health care except investment in health care buildings and facilities) was expenses "out of pocket"—that is, paid directly by individuals. Most health care spending, 72%, was paid for by some kind of insurance. Of this 72%, considerably less than half was private insurance; the rest was some kind of government insurance, mainly Medicare and Medicaid. To understand why, we need to examine the special economics of health care.

FIGURE 18-5 Who Paid for U.S. Health Care in 2009?



In the United States in 2009, insurance paid for 72% of health care consumption costs: the sum of 34% (private insurance), 22% (Medicare), and 16% (Medicaid). The percentage paid for by private insurance, 34%, was a uniquely high number among advanced countries. Even so, substantially more U.S. health care was paid for by Medicare, Medicaid, and other government programs than by other means.

Source: Department of Health and Human Services Centers for Medicare and Medicaid Services.

The Need for Health Insurance

In 2009, U.S. personal health care expenses were $8,086 per person—17.6% of gross domestic product. This did not, however, mean that the typical American spent more than $8,000

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Under **private health insurance**, each member of a large pool of individuals pays a fixed amount annually to a private company that agrees to pay most of the medical expenses of the pool's members.

on medical treatment. In fact, in any given year half the population incurs only minor medical expenses. But a small percentage of the population faces huge medical bills, with 10% of the population typically accounting for almost two-thirds of medical costs.

Is it possible to predict who will have high medical costs? To a limited extent, yes: there are broad patterns to illness. For example, the elderly are more likely to need expensive surgery and/or drugs than the young. But the fact is that anyone can suddenly find himself or herself needing very expensive medical treatment, costing many thousands of dollars in a very short time—far beyond what most families can easily afford. Yet nobody wants to be unable to afford such treatment if it becomes necessary.

Private Health Insurance Market economies have an answer to this problem: health insurance. Under **private health insurance,** each member of a large pool of individuals agrees to pay a fixed amount annually (called a *premium*) into a common fund that is managed by a private company, which then pays most of the medical expenses of the pool's members. Although members must pay fees even in years in which they don't have large medical expenses, they benefit from the reduction in risk: if they do turn out to have high medical costs, the pool will take care of those expenses.

There are, however, inherent problems with the market for private health insurance. These problems arise from the fact that medical expenses, although basically unpredictable, aren't *completely* unpredictable. That is, people often have some idea whether or not they are likely to face large medical bills over the next few years. This creates a serious problem for private health insurance companies.

Suppose that an insurance company offers a "one-size-fits-all" health care policy, under which customers pay an annual premium equal to the average American's annual medical expenses, plus a bit more to cover the company's operating expenses and a normal rate of profit. In return, the insurance company pays the policyholder's medical bills, whatever they are.

If all potential customers had an equal risk of incurring high medical expenses for the year, this might be a workable business proposition. In reality, however, people often have very different risks of facing high medical expenses—and, crucially, they often know this ahead of time. This reality would quickly undermine any attempt by an insurance company to offer one-size-fits-all health insurance. The policy would be a bad deal for healthy people, who don't face a significant risk of high medical bills: on average, they would pay much more in insurance premiums than the cost of their actual medical bills. But it would be a very good deal for people with chronic, costly conditions, who would on average pay less in premiums than the cost of their care.

As a result, some healthy people are likely to take their chances and go without insurance. This would make the insurance company's average customer less healthy than the average American. This raises the medical bills the company will have to pay and raises the company's costs per customer. That is, the insurance company would face a problem called *adverse selection*, which is discussed in detail in Chapter 20. Because of adverse selection, a company that offers health insurance to everyone at a price reflecting average medical costs of the general population, and that gives people the freedom to decline coverage, would find itself losing a lot of money.

The insurance company could respond by charging more—raising its premium to reflect the higher-than-average medical bills of its customers. But this would drive off even more healthy people, leaving the company with an even sicker, higher-cost clientele, forcing it to raise the premium even more, driving off even more healthy people, and so on. This phenomenon is known as the *adverse selection death spiral*, which ultimately leads the health insurance company to fail.

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FOR INQUIRING MINDS

A CALIFORNIA DEATH SPIRAL

At the beginning of 2006, 116,000 workers at more than 6,000 California small businesses received health coverage from PacAdvantage, a "purchasing pool" that offered employees at member businesses a choice of insurance plans. The idea behind PacAdvantage, which was founded in 1992, was that by banding together, small businesses could get better deals on employee health insurance.

But only a few months later, in August 2006, PacAdvantage announced that it was closing up shop because it could no longer find insurance companies willing to offer plans to its members.

What happened? It was the adverse selection death spiral. PacAdvantage offered the same policies to everyone, regardless of their prior health history. But employees didn't have to get insurance from PacAdvantage—they were free, if they chose, to opt out and buy insurance on their own. And sure enough, healthy workers started to find that they could get lower rates by buying insurance directly for themselves, even though that meant giving up the advantages of bulk purchasing. As a result, PacAdvantage began to lose healthy clients, leaving behind an increasingly sick—and expensive—pool of customers. Premiums had to go up, driving out even more healthy workers, and eventually the whole plan had to shut down.

This description of the problems with health insurance might lead you to believe that private health insurance can't work. In fact, however, most Americans do have private health insurance. Insurance companies are able, to some extent, to overcome the problem of adverse selection two ways: by carefully *screening* people who apply for coverage and through employment-based health insurance. With screening (which we'll learn more about in Chapter 19), people who are likely to have high medical expenses are charged higher-than-average premiums—or in many cases, refusing to cover them at all. The next section explains how employment-based health insurance, a unique feature of the American workplace, also allows private health insurance to work.

Employment-Based Health Insurance For the most part, however, insurance companies overcome adverse selection by selling insurance indirectly, to peoples' employers rather than to individuals. The big advantage of *employment-based health insurance*—insurance that a company provides to its employees—is that these employees are likely to contain a representative mix of healthy and less healthy people, rather than a selected group of people who want insurance because they expect to pay high medical bills. This is especially true if the employer is a large company with thousands or tens of thousands of workers. Employers require their employees to participate in the company health insurance plan because allowing employees to opt out (which healthier ones will be tempted to do) raises the cost of providing insurance for everyone else.

There's another reason employment-based insurance is widespread in the United States: it gets special, favorable tax treatment. Workers pay taxes on their paychecks, but workers who receive health insurance from their employers don't pay taxes on the value of the benefit. So employment-based health insurance is, in effect, subsidized by the U.S. tax system. Economists estimate the value of this subsidy at about $150 billion each year.

In spite of this subsidy, however, many working Americans don't receive employment-based health insurance. Those who aren't covered include most older Americans, because relatively few employers offer workers insurance that continues after they retire; the many workers whose employers don't offer coverage (especially part-time workers); and the unemployed.

Government Health Insurance

Table 18-6 shows the breakdown of health insurance coverage across the U.S. population in 2010. A majority of Americans, almost 170 million people, received health insurance through their employers. The majority of those who didn't have

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TABLE 18-6 Number of Americans Covered by Health Insurance, 2010 (thousands)

Covered by private health insurance	**195,874**
Employment-based	169,264
Direct purchase	30,147
Covered by government	**95,003**
Medicaid	48,580
Medicare	44,327
Military health care	12,848
Not covered	**49,904**

Source: U.S. Census Bureau.

private insurance were covered by two government programs, Medicare and Medicaid. (The numbers don't add up because some people have more than one form of coverage. For example, many recipients of Medicare also have supplemental coverage either through Medicaid or private policies.)

Medicare, financed by payroll taxes, is available to all Americans 65 and older, regardless of their income and wealth. It began in 1966 as a program to cover the cost of hospitalization but has since been expanded to cover a number of other medical expenses. You can get an idea of how much difference Medicare makes to the finances of elderly Americans by comparing the median income per person of Americans 65 and older—$18,819—with average annual Medicare payments per recipient, which were more than $11,000 in 2010. As with health care spending in general, however, the average can be misleading: in a given year, about 7% of Medicare recipients account for 50% of the costs.

Denis MacDonald/Alamy

Medicare pays 60% of the cost of hip and knee replacement surgery for seniors, which comes to more than $5 billion annually.

At the beginning of 2006, there was a major expansion of Medicare, this time to cover the cost of prescription drugs. At the time Medicare was created, drugs played a relatively minor role in medicine and were rarely a major expense for patients. Today, however, many health problems, especially among the elderly, are treated with expensive drugs that must be taken for years on end, placing severe strains on some people's finances. As a result, a new Medicare program, known as Part D, was created to help pay these expenses.

Unlike Medicare, Medicaid is a means-tested program, paid for with federal and state government revenues. There's no simple way to summarize the criteria for eligibility because it is partly paid for by state governments and each state sets its own rules. Of the 48 million Americans covered by Medicaid in 2009, 25 million were children under 18 and many of the rest were parents of children under 18. Most of the cost of Medicaid, however, is accounted for by a small number of older Americans, especially those needing long-term care.

More than 12 million Americans receive health insurance as a consequence of military service. Unlike Medicare and Medicaid, which pay medical bills but don't deliver health care directly, the Veterans Health Administration, which has more than 8 million clients, runs hospitals and clinics around the country.

The U.S. health care system, then, offers a mix of private insurance, mainly from employers, and public insurance of various forms. Most Americans have health insurance either from private insurance companies or through various forms of government insurance. However, in 2010 almost 50 million people in America, 16.3% of the population, had no health insurance at all. What accounts for the uninsured, and how much does the problem of the uninsured matter?

The Problem of the Uninsured

The Kaiser Family Foundation, an independent nonpartisan group that studies health care issues, offers a succinct summary of who is uninsured in America: "The uninsured are largely low-income adult workers for whom coverage is unaffordable or unavailable." The reason the uninsured are primarily adults is that Medicaid, supplemented by SCHIP (which provides health care for children in families that are above the poverty threshold but still have relatively low income), covers many, though not all, low-income children but is much less likely to provide coverage to adults, especially if they do not have children.

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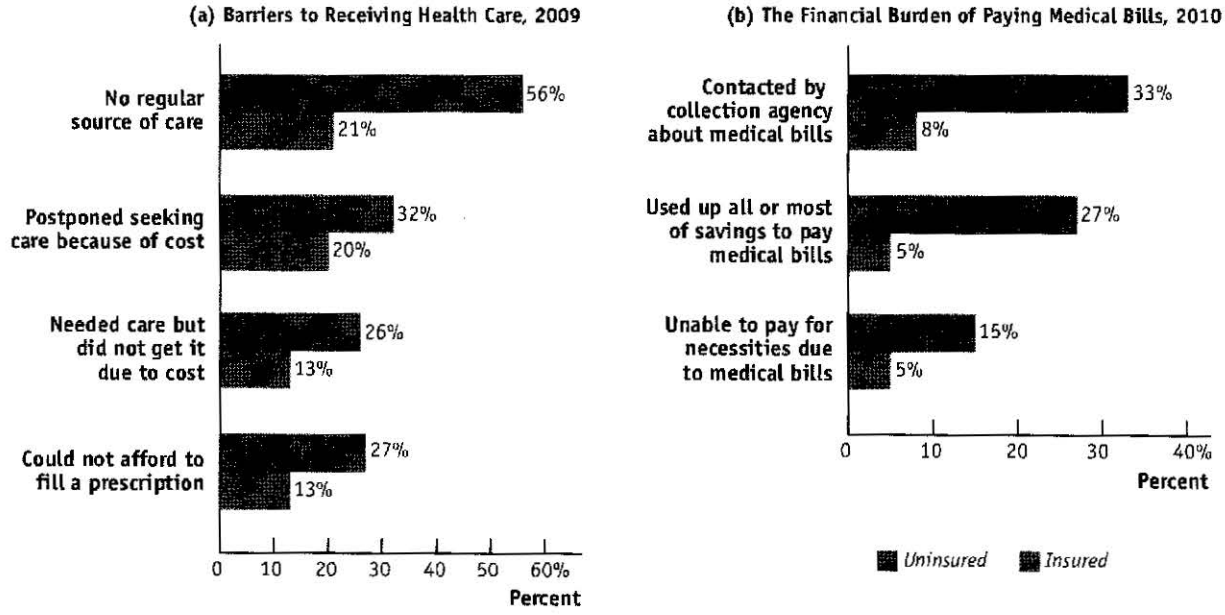
Low-income workers tend to be uninsured for two reasons: they are less likely than workers with higher income to have jobs that provide health insurance benefits, and they are less likely to be able to afford to directly purchase health insurance themselves. Finally, insurance companies frequently refuse to cover people, regardless of their income, if they have a preexisting medical condition or something in their medical history suggesting that they are likely to need expensive medical treatment at some future date. As a result, a significant number of Americans with incomes that most would consider middle class cannot get insurance.

It's important to realize that lack of insurance is not synonymous with poverty. Most people in America without health insurance have incomes above the poverty threshold, and 35% of the uninsured have incomes more than twice the poverty threshold. We should also note that some of the uninsured are relatively healthy people who could afford insurance but prefer to save money and take their chances, although there is dispute about how large the group of voluntarily uninsured is.

Like poverty, lack of health insurance has serious consequences, both medical and financial. On the medical side, the uninsured frequently have limited access to health care. Panel (a) of Figure 18-6 shows one summary of common problems associated with access to care, all of which are much worse for the uninsured than for the insured. On the monetary side, those who are uninsured often face serious financial problems when illness strikes. Panel (b) shows a summary of the main financial problems associated with medical care, all of which are much worse for those without health insurance.

FIGURE **18-6** The Consequences of Being Uninsured



As panel (a) shows, the uninsured face significantly greater barriers to receiving health care than the insured. Compared to the insured, a much higher proportion of the uninsured needed care but either did not receive it or postponed it. Panel (b) illustrates the heavy financial consequences of being uninsured. Compared to the insured, a much higher proportion of the uninsured had problems paying a medical bill.

Source: The Henry J Kaiser Family Foundation, *The Uninsured: A Primer.*

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A **single-payer system** is a health care system in which the government is the principal payer of medical bills funded through taxes.

Health Care in Other Countries

Health care is one area in which the United States is very different from other wealthy countries, including both European nations and Canada. In fact, we're distinctive in three ways. First, we rely much more on private health insurance than any other wealthy country. Second, we spend much more on health care per person. Third, we're the only wealthy nation in which large numbers of people lack health insurance.

Table 18-7 compares the United States with three other wealthy countries: Canada, France, and Britain. The United States is the only one of the four countries that relies on private health insurance to cover most people; as a result, it's the only one in which private spending on health care is (slightly) larger than public spending on health care.

TABLE **18-7** Health Care Systems in Advanced Countries (2009 data unless indicated)

	Government share of health care spending	Health care spending per capita (US$, purchasing power parity)	Life expectancy (total population at birth, years)	Infant mortality (deaths per 1,000 live births)
United States	47.7%	$7,960	78.2	6.5[2]
Canada	70.6	4,363	80.7[1]	5.1[1]
France	77.9	3,978	81.5[3]	3.7[3]
Britain	84.1	3,487	80.4	4.6

Source: OECD. 2008 data except: (1) 2007 data; (2) 2008 data; (3) 2010 data.

Canada has a **single-payer system:** a health care system in which the government acts as the principal payer of medical bills funded through taxes. For comparison, Medicare is essentially a single-payer system for older Americans—and the Canadian system is, in fact, called Medicare. The British system is like the American Veterans Health Administration, extended to everyone: a government agency, the British National Health Service, employs health care workers and runs hospitals and clinics that are available free of charge to the public. France is somewhere in between the Canadian and British systems. In France, the government acts as a single-payer, providing health insurance to everyone, and French citizens can receive treatment from private doctors and hospitals; but they also have the choice of receiving care from a sizable health care system run directly by the French government.

All three non-U.S. systems provide health insurance to all their citizens; the United States does not. Yet all three spend much less on health care per person than we do. Many Americans assume this must mean that foreign health care is inferior in quality. But many health care experts disagree with the claim that the health care systems of other wealthy countries deliver poor-quality care. As they point out, Britain, Canada, and France generally match or exceed the United States in terms of many measures of health care provision, such as the number of doctors, nurses, and hospital beds per 100,000 people. It's true that U.S. medical care includes more advanced technology in some areas and many more expensive surgical procedures. U.S. patients also have shorter waiting times for elective surgery than patients in Canada or Britain. France, however, also has very short waiting times.

Surveys of patients seem to suggest that there are no significant differences in the quality of care received by patients in Canada, Europe, and the United States. And as Table 18-7 shows, the United States does considerably worse than other advanced countries in terms of basic measures such as life expectancy and infant mortality, although our poor performance on these measures may have causes other than the quality of medical care—notably our relatively high levels of poverty and income inequality.

So why does the United States spend so much more on health care than other wealthy countries? Some of the disparity is the result of higher doctors' salaries, but most studies suggest that this is a secondary factor. One possibility is that Americans are getting better care than their counterparts abroad, but in

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ways that don't show up in either surveys of patient experiences or statistics on health performance.

However, the most likely explanation is that the U.S. system suffers from serious inefficiencies that other countries manage to avoid. Critics of the U.S. system emphasize the fact that our system's reliance on private insurance companies, which expend resources on such activities as marketing and trying to identify and weed out high-risk patients, leads to high operating costs. On average, the operating costs of private health insurers eat up 14% of the premiums clients pay, leaving only 86% to spend on providing health care. By contrast, Medicare spends only 3% of its funds on operating costs, leaving 97% to spend on health care. A study by the McKinsey Global Institute found that the United States spends almost six times as much per person on health care administration as other wealthy countries. Americans also pay higher prices for prescription drugs because in other countries government agencies bargain with pharmaceutical companies to get lower drug prices.

The 2010 Health Care Reform

However one rates the past performance of the U.S. health care system, by 2009 it was clearly in trouble. The root of the problem was the rising cost of health insurance, both private and public.

An immediate problem is that the cost of private insurance has been rising much faster than incomes. From 1999 to 2009 the average premiums for employment-based health insurance more than doubled, but the wages of the average worker rose only 35%. By 2009, the average cost of insurance for a family of four was almost $14,000.

As a result of these rising costs, employment-based health insurance, the centerpiece of the system for Americans under 65, is in decline. Figure 18-7 shows selected changes in the insurance status of Americans between 2000 and 2009. Over that period, while the total population rose by 25 million, the number of people with employment-based health insurance declined by almost 10 million. Despite the expansion of Medicaid by 18 million people, by 2009 12 million people joined the ranks of the uninsured.

At the same time, as private health insurance is faltering and the ranks of the uninsured increase, public health insurance is coming under increasing financial strain. Partly this is because Medicaid and other government programs now cover more people than in the past. Mainly, however, it is because the cost per beneficiary of government health insurance, like the cost per beneficiary of private insurance, has been rising rapidly.

FIGURE **18-7** Changes in Health Insurance Status, 2000–2009

Since 2000, the U.S. population has grown substantially, but the number of people with employment-based health insurance has actually declined. Growth in public health insurance, mainly Medicaid, made up part of the difference. There has also, however, been an increase in the number of uninsured.

Source: U.S. Census Bureau.

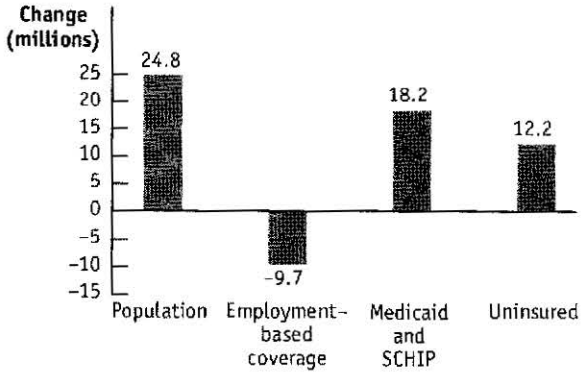

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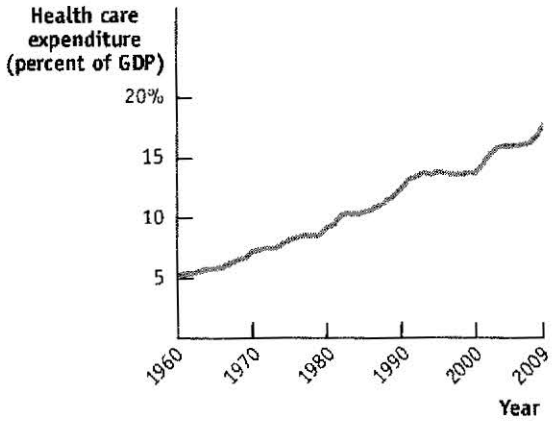
FIGURE **18-8** Rising Health Care Costs

U.S. health care spending as a percentage of GDP, a measure of total income, has tripled since 1965. Similar trends can be seen in other countries. Most analysts believe that the main force behind this trend is medical progress: we spend more on health care because more medical problems are treatable.

Source: Department of Health and Human Services Centers for Medicare and Medicaid Services.



What's behind these rising costs? Figure 18-8 shows overall U.S. spending on health care as a percentage of GDP, a measure of the nation's total income, since the 1960s. As you can see, health spending has tripled as a share of income since 1965; this increase in spending explains why health insurance has become more expensive. Similar trends can be observed in other countries.

Why is health spending rising? The consensus of health experts is that it's a result of medical progress. As medical science progresses, conditions that could not be treated in the past become treatable—but often only at great expense. Both private insurers and government programs feel compelled to cover the new procedures—but this means higher costs, which either have to be passed on in the form of higher insurance premiums or require larger commitments of taxpayer funds.

The combination of a rising number of uninsured and rising costs has led to many calls for health care reform in the United States. And in 2010 Congress passed comprehensive health care reform legislation, officially known as the Patient Protection and Affordable Care Act (PPACA), or ACA for short.

ACA, which won't take full effect until 2014, is the largest expansion of the American welfare state since the creation of Medicare and Medicaid in 1965. It has two major objectives: covering the uninsured and cost control. Let's look at each in turn.

Covering the Uninsured On the coverage side, the ACA closely follows a model that has already been tested in Massachusetts, which introduced a very similar plan—under Republican then-governor and subsequent presidential hopeful Mitt Romney—in 2006. To understand the logic of both the Massachusetts plan and ACA, consider the problem facing one major category of uninsured Americans: the many people who seek coverage in the individual insurance market but are turned down because they have preexisting medical conditions, which insurance companies fear could lead to large future expenses. (Insurance companies have been known to deny coverage for even minor ailments, like allergies or a rash you had in college.) How can insurance be made available to such people?

One answer would be regulations requiring that insurance companies offer the same policies to everyone, regardless of medical history—a rule known as "community rating." In fact, a number of states have such a rule. But community rating tends to lead to an adverse selection death spiral: Healthy individuals don't buy insurance until or unless they get sick, and because only people with health problems are getting coverage, insurance becomes very expensive.

To make community rating work, it's necessary to supplement it with other policies. Both the Massachusetts reform and ACA add two key features. First is

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the requirement that everyone purchase health insurance—known as the *individual mandate.* This prevents an adverse selection death spiral. Second, government subsidies make the required insurance affordable for lower- and lower-middle income families.

It's important to realize that this system is like a three-legged stool: all three components must be present in order for it to work. Take away community rating, and those with preexisting conditions won't get coverage. Take away the individual mandate, and community rating will produce an adverse selection death spiral. And you can't require that people buy insurance without providing subsidies to those with lower incomes.

Will this arrangement, once fully implemented, succeed in covering more or less everyone? The Massachusetts precedent is encouraging on that front: by 2010, more than 98% of the state's residents had health insurance and virtually all children were covered. Since the ACA is very similar in structure, it ought to produce similar results.

Cost Control But will ACA control costs? In itself, the expansion of coverage will raise health care spending, although not by as much as you might think. The uninsured are by and large relatively young, and the young have relatively low health care costs. (The elderly are already covered by Medicare.) The question is whether the reform can succeed in "bending the curve": reducing the rate of growth of health costs over time.

ACA's promise to control costs starts from the premise that the U.S. medical system, as currently constituted, has skewed incentives that waste resources. Because most care is paid for by insurance, neither doctors nor patients have an incentive to worry about costs. In fact, because health care providers are generally paid for each procedure they perform, there's a financial incentive to provide additional care—do more tests and, in some cases, perform more operations—even when there are little or no medical benefits.

The bill attempts to correct these skewed incentives in a variety of ways, from stricter oversight of reimbursements, to linking payments to a procedure's medical value, to paying health care providers for improved health outcomes rather than the number of procedures, and by limiting the tax deductibility of employment-based plans. Even supporters of the reform admit that nobody knows how well any one of these measures will work, but they point out that ACA incorporates virtually every idea for cost control that has been proposed by health care economists and that some of these ideas are likely to be highly successful. Or they will be successful if the reform ever goes fully into effect.

ECONOMICS IN ACTION

WHAT MEDICAID DOES

Do social insurance programs actually help their beneficiaries? The answer isn't always as obvious as you might think. Take the example of Medicaid, which provides health insurance to low-income Americans. Some skeptics about the program's effectiveness have argued that in the absence of Medicaid, the poor would still find ways to get essential health care, and that there is no clear evidence that receiving Medicaid actually leads to better health.

Testing such assertions is tricky. You can't just compare people who are on Medicaid with people who aren't, since the program's beneficiaries differ in many ways from those who aren't on the program. And we don't normally get to do controlled experiments in which otherwise comparable groups receive different government benefits.

Tom Stewart/Corbis

Medicaid has been shown to make a big difference in the well-being of recipients.

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Once in a while, however, events provide the equivalent of a controlled experiment—and that's what happened with Medicaid. In 2008, the state of Oregon—which had sharply curtailed its Medicaid program because it lacked sufficient funds—found itself with enough money to put some but not all deserving recipients back on the program. To allocate the limited number of slots, the state used a lottery. And there you had it: in effect, a controlled experiment, in which researchers could compare a random sample of people receiving Medicaid with similar people who didn't win the lottery.

So what were the results? It turned out that Medicaid made a big difference. Those on Medicaid received

- 60% more mammograms
- 35% more outpatient care
- 30% more hospital care
- 20% more cholesterol checks

Medicaid recipients were also

- 70% more likely to have a consistent source of care
- 55% more likely to see the same doctor over time
- 45% more likely to have had a pap test within the last year (for women)
- 40% less likely to need to borrow money or skip payment on other bills because of medical expenses
- 25% percent more likely to report themselves in "good" or "excellent" health
- 15% more likely to use prescription drugs
- 15% more likely to have had a blood test for high blood sugar or diabetes
- 10% percent less likely to screen positive for depression

In short, Medicaid led to major improvements in access to medical care and the well-being of those receiving it. That doesn't necessarily mean that the program is a good thing, since it does, after all, cost taxpayers a significant amount of money. But the Oregon results showed that one criticism of Medicaid—the claim that it doesn't work at all—isn't valid.

- Health insurance satisfies an important need because expensive medical treatment is unaffordable for most families. **Private health insurance** has an inherent problem: the adverse selection death spiral. Screening by insurance companies reduces the problem, and employment-based health insurance, the way most Americans are covered, avoids it altogether.
- The majority of Americans not covered by private insurance are covered by Medicare, which is non-means-tested **single-payer system** for those over 65, and Medicaid, which is available based on income.
- Compared to other wealthy countries, the United States depends more heavily on private health insurance, has higher health care spending per person, higher administrative costs, and higher drug prices, but without clear evidence of better health outcomes.
- Health care costs everywhere are increasing rapidly due to scientific progress. The 2010 ACA legislation was designed to address the large and growing share of American uninsured and to reduce the rate of growth of health care spending.

Check Your Understanding 18-3

1. If you are enrolled in a four-year degree program, it is likely that you are required to enroll in a health insurance program run by your school.
   a. Explain how you and your parents benefit from this health insurance program even though, given your age, it is unlikely that you will need expensive medical treatment.
   b. Explain how your school's health insurance program avoids the adverse selection death spiral.
2. According to its critics, what accounts for the higher costs of the U.S. health care system compared to those of other wealthy countries?

Solutions appear at back of book.

The Debate over the Welfare State

The goals of the welfare state seem laudable: to help the poor, to protect against severe economic hardship and to ensure access to essential health care. But good intentions don't always make for good policy. There is an intense debate about how large the welfare state should be, a debate that partly

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reflects differences in philosophy but also reflects concern about the possibly counterproductive effects on incentives of welfare state programs. Disputes about the size of the welfare state are also one of the defining issues of modern American politics.

Problems with the Welfare State

There are two different arguments against the welfare state. One, which we described earlier in this chapter, is based on philosophical concerns about the proper role of government. As we learned, some political theorists believe that redistributing income is not a legitimate role of government. Rather, they believe that government's role should be limited to maintaining the rule of law, providing public goods, and managing externalities.

The more conventional argument against the welfare state involves the trade-off between efficiency and equity, an issue that we first encountered in Chapter 7. As we explained there, the *ability-to-pay-principle*—the argument that an extra dollar of income matters more to a less well-off individual than to a more well-off individual—implies that the tax system should be progressive, with high-income taxpayers paying a higher fraction of their income in taxes than those with lower incomes.

But this must be balanced against the efficiency costs of high marginal tax rates. Consider an extremely progressive tax system that imposes a marginal rate of 90% on very high incomes. The problem is that such a high marginal rate reduces the incentive to increase a family's income by working hard or making risky investments. As a result, an extremely progressive tax system tends to make society as a whole poorer, which could hurt even those the system was intended to benefit. That's why even economists who strongly favor progressive taxation don't support a return to the extremely progressive system that prevailed in the 1950s, when the top U.S. marginal income tax rate was more than 90%. So, the design of the tax system involves a trade-off between equity and efficiency.

A similar trade-off between equity and efficiency implies that there should be a limit to the size of the welfare state. A government that operates a large welfare state requires more revenue than one that restricts itself mainly to provision of public goods such as national defense. A large welfare state requires higher tax revenue and higher marginal tax rates than a smaller welfare state.

Table 18-8 shows "social expenditure," a measure that roughly corresponds to total welfare state spending, as a percentage of GDP in the United States, Britain, and France. It also compares this with an estimate of the marginal tax rate faced by an average single wage-earner, including payroll taxes paid by employers and state and local taxes. As you can see, France's large welfare state goes along with a high marginal rate of taxation. As the upcoming Economics in Action explains, some but not all economists believe that this high rate of taxation is a major reason the French work substantially fewer hours per year than Americans.

TABLE **18-8** Social Expenditure and Marginal Tax Rates

	Social expenditure in 2007 (percent of GDP)	Marginal tax rate in 2009
United States	16.2%	34.4%
Britain	20.5	38.8
France	28.4	52.0

Source: OECD. Marginal tax rate is defined as a percentage of total labor costs.

One way to hold down the costs of the welfare state is to means-test benefits: make them available only to those who need them. But means-testing benefits creates a different kind of trade-off between equity and efficiency. Consider the following example: Suppose there is some means-tested benefit, worth $2,000 per year, that is available only to families with incomes of less than $20,000 per year. Now suppose that a family currently has an income of $19,500 but that one

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