# Session 5: Health, education, and poverty

*To serve the uninsured, America does not need any more doctors or any more hospitals; it needs policies to reallocate their services.*

Paul Starr

*We know enough, I would hazard, to suggest that greater resources would be most usefully spent in preschools and elementary schools.*

Nathan Glazer

## Providing health care for the poor

Paul Starr emphasized the fact that health programs have improved the health status of the poor and have expanded their access to medical care, gains which have been achieved at substantial budgetary cost. The problems that remain include the lack of health insurance coverage for many of the poor and the recent narrowing of access for those who receive some services.

### Historical legacies

Starr began by describing four "encumbrances of history" that have shaped delivery of health care in America. One he termed the "welfare piggyback," referring to the channeling of governmental health services for the poor through public assistance rather than through a universal social insurance system or a national public health service, the two systems employed in Europe. The social insurance programs initiated during the New Deal offered income replacement for the unemployed and the elderly, not health care. Concern over the medical needs of the aged led to passage in 1965 of Medicare, an insurance program for those over 65. Its companion program, Medicaid, was set up as a form of public assistance offering medical services only to certain "deserving" groups: the blind and disabled, the aged not covered by Medicare, and AFDC recipients. Left out were two-parent families and single adults who were neither aged nor disabled, regardless of how poor they were. In consequence,

> Medicare enjoys the political protection created by a span of eligibility that includes the middle class; Medicaid suffers from the political vulnerability created by identification with welfare and the poor. The hospital benefits of Medicare are additionally protected by the fact that its financing comes from an earmarked payroll tax, which cannot be tapped for other purposes, whereas Medicaid must compete for general revenues—at not only the federal but also the state level (p. 17).

Another burden of the past is the legacy of political accommodation, stemming from the fashion in which Medicaid and Medicare were shaped by legislative and political deference to the health care industry. This "policy of appeasement" meant expenditures were rarely monitored or limited, and their enormous growth has now prompted structural changes in health care financing that may reduce access of the poor to services, as we will see below.

The third encumbrance consists of fiscal asymmetry in federal financing of health care, exemplified by the fact that federal tax subsidies for employee benefit plans are much higher than federal direct expenditures on Medicaid (the tax subsidies are, moreover, regressive: the higher the employee's income, the higher the subsidy). The fourth concerns adverse public perceptions of welfare recipients, such as the popular view that most Medicaid beneficiaries are members of black welfare families of working age when in fact two-thirds of those expenditures support the aged and disabled, many of whom are in nursing homes.

### The record of public programs

Antipoverty programs of the 1960s brought health care within reach of the disadvantaged either by providing services directly, usually through community health centers, or by subsidizing such services, primarily through Medicaid. The number of neighborhood health centers grew slowly. Although 1,000 were projected under the plan of 1967, the maximum reached was 800, serving over 4 million with staff assistance from the National Health Service Corps, during the Carter administration. Studies show that the centers have significantly improved the health of their community members, and have done so at lower per-patient cost than Medicaid.[1] Yet their success has gone relatively unnoticed, and their current funding status is uncertain.

Medicaid became the main channel for federal and state funds, and expenditures on it grew steadily from $2.5 billion in 1967 to $9 billion in 1973 to about $30 billion in 1982. In recent years Medicaid expenditures have shifted toward hospitals and nursing homes, and away from primary and preventive care. The Omnibus Budget Reconciliation Act of 1981 withdrew Medicaid's protection from about one million people, chiefly as a result of reduced public assistance for the working poor. The ratio of Medicaid beneficiaries to the poverty population as a whole fell to .45 in 1982, down from .53 in 1979 and .59 in 1970.

One measure of the programs' effect on access is the extent to which portions of the population remain uninsured, a calculation made difficult in the past owing to the lack of consistent time-series data. Since 1979 the March Current Population Survey, conducted by the Census Bureau, has asked a question from which we have learned that the number of those under 65 who lack any form of health insurance rose 15 percent over the period 1979–82. Of those without insurance, one-third had incomes below the poverty line while another third had incomes between 100 and 200 percent of the line. Furthermore, underlining the point made by

Blank and Blinder concerning the harm suffered by the poor during a recession, many primary earners lost health insurance when they became jobless during the recent economic downturn, whereas in earlier recessionary periods secondary workers were those more likely to become unemployed and remained protected by a primary worker's health benefit.

### Assessing changes in health of the poor

Since 1965 public expenditures on health care have mushroomed, and the question is what effect they have had on the population in general and the poor in particular. The gloomy conclusion of studies in the mid-1970s was that even though differences in access to health care by the poor and nonpoor had considerably narrowed, greater spending on health had not improved it. Ten years later, the data seem to indicate the reverse: recent studies reveal serious inequities in access, but indicators of health status show marked improvement. Life expectancy, which remained unchanged in the decade preceding 1965, began to increase in 1968 and by 1980 had lengthened by four years. Mortality rates fell 20 percent over that period and infant mortality rates were cut in half (although recent data indicate that their decline has slowed dramatically).

Because we lack good information linking health and income, we cannot evaluate with precision the relative experience of the poor, but the fact that black infant mortality rates have declined considerably may serve as at least one proxy measure, supporting optimism concerning gains in the physical well-being of the poor. Studies of neighborhood health centers contribute to that optimism by demonstrating the effectiveness of their medical care.

### Prospects in the 1980s

Retrenchment and cost containment are the current watchwords and, according to Starr, structural changes in the health care industry do not bode well for the poor. Competition among hospitals has increased, and those facing the greatest financial stress have more Medicaid patients and fewer patients with private health insurance. Starr speculated that such hospitals might try to reduce services for the poor—by making them feel unwelcome, by closing the emergency rooms that lead the poor into hospitals, by sending the poor who seek admission to a public hospital, if one exists in the same locality. There is in fact anecdotal evidence that these strategies are being pursued. Moreover, an increasing proportion of hospitals are owned or managed by for-profit companies, and the general ethos of the industry is shifting toward sound business management rather than community service. Combined with cutbacks in public programs, these developments suggest that we cannot sustain the gains of the past.

New payment systems, designed to contain Medicaid and Medicare costs, may also adversely affect delivery of health care to the poor. Federal legislation in 1981 freed states of the obligation to reimburse Medicaid providers on a cost-of-service basis, allowing them to experiment with such other mechanisms as capitation payments—a flat fee per patient, putting the provider at risk for the cost of services rendered.

Lack of insurance protection for the poor is another source of concern; so are reductions in other programs that will have repercussions on health services. For example, termination of assistance to medical students means that the National Health Service Corps may have fewer physicians to place in underserved areas, and the free-care obligations of hospitals constructed with federal support under the Hill-Burton Act are now expiring.

Starr concluded that the answer to these problems was not necessarily to spend more, an unrealistic expectation given today's economic and political climate, but to undertake "a series of measures that chip away at the residual population of the uninsured" (p. 59). He suggested eliminating the categorical restrictions of Medicaid, requiring and subsidizing employers' health insurance coverage for employees who are laid off or fired and/or allowing them to buy into Medicaid, and establishing more effective insurance mechanisms for industries in which coverage is low, such as agriculture or retail trade. The costs of these changes need not be met by increasing national expenditures, but by using the savings that are being realized through such changes as health maintenance organizations and by reducing federal tax subsidies of benefit plans. Reallocation of existing services rather than their expansion would help close the gaps in coverage, in Starr's view.

### Comment

In discussing Starr's paper, Jack Meyer suggested that even greater emphasis should be given to the affordability of providing for those currently in need, not only by reducing system inefficiencies and rearranging subsidies among the poor but also by correcting the inequities that result from cutting subsidies to the poor while continuing to grant subsidies to business, to wealthy households, and to high-cost doctors. He strongly criticized "the unconscionable discrimination against certain types of poor people," specifically the working poor, stemming from policies of the present administration. That discrimination was not invented by this administration, he stressed, for it has long been a feature of our welfare system, but it has been exacerbated by recent legislation.

The commercialization of health care described by Starr will, Meyer agreed, result in savings that should be devoted to closing the gaps in health care for the poor. Meyer urged installation of an adequate safety net that would utilize these gains to the advantage of those most vulnerable in our society, essentially the same recommendation that Starr made; but Meyer went further by stating that if the cost of the safety net exceeds efficiency gains, the bill should be paid by increasing the taxes of middle- and upper-income groups and/or by cutting benefits that are not really needed.

## Education and training: Does anything work?

Like Starr's paper, the presentation by Nathan Glazer served as a corrective to the views of the 1970s that antipoverty programs had little if any effect. Glazer cited new evaluative studies that refute, to some extent, the earlier conclusions that "nothing works"—that despite expensive and intensive efforts to provide compensatory education to disadvantaged students, to give children from poor families a head start in the classroom, and to offer job training to high school dropouts and delinquents, cognitive skills were little improved and the later earnings of program participants were not increased. The current perspective is different, Glazer asserted, in part because new studies show new results, and in part because a policy of redistributing income to the poor is even less favored today as an antipoverty strategy than it was ten years ago. Instead, education appears to retain popular support as a means to reduce poverty.

### Early intervention

He selected several analyses that illustrate the swing to more optimistic points of view. One study concerned the preschool programs offered in the 1960s.[2] In terms of the performance of students and their control groups ten years later, the results indicated substantial differences—not in IQ or test scores, but in whether or not the students were held back in grade or assigned to special education classes. Judged by these standards, participants showed improvement over the controls. The results were consistently positive across a variety of programs for children ranging in age from 1 to 5. Modest outcomes, perhaps, but nevertheless suggestive that something works, at least at earlier ages.

Another study dealt with elementary education.[3] Funded by the Department of Education, it compared over a three-year period the performance of poor and disadvantaged students receiving compensatory education services with that of poor children who did not. The compensatory services—small classes, individual instruction from committed teachers—were provided under Title I of the Elementary and Secondary Education Act of 1965 (now Chapter I of the Educational Consolidation and Improvement Act of 1981). The principal finding was that compensation did increase educational achievement. By the time the students reached junior high, however, the positive effects had faded.

These studies and others indicate in Glazer's view that there is merit to intervention at lower grade levels on behalf of disadvantaged children. It is of course easier to make gains in earlier grades, where minimal abilities in reading and mathematics are taught. At the secondary school level, such skills as making inferences, analyzing and interpreting, and solving problems are involved, and the record of educational programs for poor students remains discouraging at this level.

### High school and beyond

If more students graduated from high school and if they became more adept in the skills taught in school, the problems of unemployment and low earnings would be much reduced. Glazer joined other conference paper authors in searching for causes of the rise of unemployment among disadvantaged youth. A study conducted by the National Bureau of Economic Research[4] of young black men living in the inner-city areas of Boston, Philadelphia, and Chicago found that their deteriorating employment situation could not be attributed to discrimination, which undeniably exists but is not thought to have increased in recent years, nor to the entry of young women and immigrants into the labor force, nor to the unavailability of jobs in the suburbs, since living in inner-city neighborhoods with easy access to suburban jobs did not increase employment chances among these teenagers. Three factors did improve their probability of holding a job: attending church, staying in school longer, and getting better grades. On the other hand, those who lived in welfare families and in public housing had lower earnings than their counterparts with the same family income and other attributes but who lived in private housing and did not receive public assistance.

For those young people from poor families who are not in school and not employed, Glazer concluded that work training is the public program of next resort. Yet, in his words,

> when it comes to what works in work training for the inadequately educated, the despairing or dulled or drugged or vicious or those frustrated by their own absent but crucially necessary minimal skills, the situation is far more complicated than even the discussion of what works in the education of the children of the poor and of minorities in the lower grades (p. 37).

Evaluations of our training programs, summarized in a recent study, indicate that the "mainstream" institutions of vocational training institutes, secondary schools, and colleges should be utilized in place of special training programs, because they offer incentives and afford credentials recognizable in the labor market.[5] Yet even if we should put into effect what we have learned from these evaluations, Glazer was pessimistic about the long-range results of training efforts. The recent Youth Incentive Entitlement Pilot Project, an ambitious program which succeeded in increasing the earnings of black teenagers, failed to reduce dropout rates or increase high school graduation rates.

His conclusion was that our resources should be directed toward preschools and elementary schools, since the evidence indicates that improvement there is possible. If broadened and sustained, that improvement might enable poor young people to get through high school and to face better job prospects.

## A difference of opinion

Christopher Jencks, discussant for the paper and one of the educationists cited by Glazer as having argued in the 1970s that nothing works, took issue with some of Glazer's optimistic conclusions. The more positive tone of evaluations today results primarily, he asserted, from a "revolution of declining expectations" about what compensatory programs should be expected to accomplish. We now ask not that the programs close the gap in academic performance between poor and middle-class children over the long run; we applaud the fact that they have a detectable short-term effect.

The technical changes in studies that have prompted a more favorable opinion of compensatory education include use of larger sample sizes, which are more likely to reveal the underlying positive effects than are small samples; "meta-analysis," or averaging across studies, which shifts analytic emphasis away from testing for significance and toward the absolute magnitude of program effects; and the use of different outcome measures, defining "improvement" as being promoted rather than held back and not being assigned to special education classes.

The positive conclusions of these studies were disputed by Jencks not because he disagreed with their analytic findings, but because most studies show very little long-term effect on cognitive growth. Furthermore, even when poor children do as well in elementary school as their middle-class counterparts, their later life chances remain significantly worse. Jencks also questioned Glazer's conclusion that compensatory education should focus on elementary schools. In the early years students have more than one chance to learn the basic skills of reading and math, since those subjects are repeated from grade to grade. But this is not true of biology or algebra in high school; if the student does not learn it the first time he or she takes the course, the opportunity will probably not occur again short of college, and it is unlikely that this student will enter higher education.

The main recommendation offered by Jencks was that secondary schools should be the focus of efforts to improve our educational system. "The decline in test performance in American secondary schools over the past fifteen years and the increase in dropout rates are, I would argue, byproducts of deliberate decisions"—the decision not to make an effort to teach basic skills in high school and the decision not to impose meaningful penalties for failure to perform assignments or for breaking social rules. Intervention later, as well as earlier, is needed if we are to better the prospects of disadvantaged students.■

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[1]Starr's account of the community health centers drew from H. Jack Geiger, "Community Health Centers: Health Care as an Instrument of Social Change," in *Reforming Medicine: The Lessons of the Last Quarter Century*, ed. V. W. Sidel and R. Sidel (New York: Pantheon, 1984), and Karen Davis and Cathy Shoen, *Health and the War on Poverty: A Ten-Year Appraisal* (Washington, D.C.: Brookings Institution, 1978).

[2]Irving Lazar and Richard Darlington, *Lasting Effects after Preschool*, U.S. Department of Health, Education, and Welfare, Publication No. 79-178 (Washington, D.C.: HEW, 1978).

[3]See Launor F. Carter, "The Sustaining Effects Study of Compensatory and Elementary Education," *Educational Researcher, 13* (1984), 4-13.

[4]The survey results were reviewed by Richard B. Freeman and Harry J. Holzer, "Young Blacks and Jobs—What We Now Know," *The Public Interest* (Winter 1985), pp. 18-31.

[5]Robert Taggart, *A Fisherman's Guide: An Assessment of Training and Remediation Strategies* (Kalamazoo, Mich.: Upjohn Institute for Employment Research, 1981).

# ASPE-Institute workshop

The third annual workshop sponsored by the Institute and the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services was held in Madison May 2-3, 1985. The following investigators presented papers on their ongoing research:

- Rebecca M. Blank, Princeton University: "Analyzing the Cyclicality of Incomes"
- Mary E. Corcoran and Paul N. Courant, University of Michigan: "Sex-Role Socialization and Occupational Segregation: An Empirical Investigation"
- David T. Ellwood, Harvard University: "Working Off of Welfare: Policies and Prospects for Self-Sufficiency of Female Family Heads"
- Robert M. Entman, Duke University: "The Public Opinion Impacts of Media Messages"
- Karen C. Holden, IRP, Richard V. Burkhauser, Daniel A. Myers, Vanderbilt University: "The Dynamics of Poverty among the Elderly: Income Transitions at Older Stages of Life"
- Robert M. Hutchens and George Jakubson, Cornell University, Saul Schwartz, Tufts University: "Living Arrangements, Employment, Schooling and Welfare Recipiency of Young Women: A Progress Report"
- Thomas J. Kniesner, University of North Carolina, Marjorie B. McElroy, Duke University, and Steven P. Wilcox, University of North Carolina: "Getting Poor Without a Husband and Getting Out With or Without"
- Edward N. Wolff, New York University: "Social Security, Pensions, and the Wealth Holdings of the Poor"