The Economics of the Welfare State

INSURING CHILDREN’S HEALTH

Senator Ted Kennedy of Massachusetts, a liberal Democrat, and Senator Orrin Hatch of Utah, a conservative Republican, didn’t see eye to eye on much in the 1990s. Yet the two men came together in 1997 to sponsor a bill creating a new government program known as SCHIP (pronounced “ess-chip”), the State Children’s Health Insurance Program.

SCHIP, as its name suggests, provides health insurance to children. (The “state” in the title refers to the fact that the federal government provides grants to the states, rather than running the program directly itself.) It wasn’t the first child health insurance program: in 1997 there were already almost 15 million American children receiving health coverage from Medicaid, a program designed to help the poor. What SCHIP did was extend coverage to several million more children, those in families with incomes too high to qualify for Medicaid but not, in the judgment of the program’s creators, high enough to afford private health insurance.

A decade after its creation, SCHIP would become the object of a tough political fight between Democrats who wanted to expand the program and Republicans who didn’t. But it’s revealing that the program was originally created through a bipartisan initiative. In modern America, politicians often disagree about how much help lower-income families should receive to pay for their health care, housing, food, and other items, but there is a broad political consensus that they should receive some help. And they do.

It’s the same around the world. Modern governments, especially in wealthy countries, devote a large chunk of their budgets to health care, income support for the elderly, aid to the poor, and other programs that reduce economic insecurity and, to some degree, income inequality. The collection of government programs devoted to these tasks is known as the welfare state.

We start this chapter by discussing the underlying rationale for welfare state programs. Then we’ll describe and analyze the two main kinds of programs operating in the United States: income support programs, of which Social Security is by far the largest, and health care programs, dominated by Medicare and Medicaid.
Poverty, Inequality, and Public Policy

During World War II a British clergyman gave a speech in which he contrasted the “warfare state” of Nazi Germany, dedicated to conquest, with Britain’s “welfare state,” dedicated to serving the welfare of its people. Since then, the term welfare state has come to refer to the collection of government programs that are designed to alleviate economic hardship. A large share of the government spending of all wealthy countries consists of government transfers—payments by the government to individuals and families—that provide financial aid to the poor, assistance to unemployed workers, guaranteed income for the elderly, and assistance in paying medical bills for those with large health care expenses.

The Logic of the Welfare State

Suppose that the Taylor family, which has an income of only $15,000 a year, were to receive a government check for $1,500. This check might allow the Taylors to afford a better place to live, eat a more nutritious diet, or in other ways significantly improve their quality of life. Also suppose that the Fisher family, which has an income of $300,000 a year, were to face an extra tax of $1,500. This probably wouldn’t make much difference to their quality of life: at worst, they might have to give up a few minor luxuries.

This hypothetical exchange illustrates one major rationale for the welfare state: alleviating income inequality. Because a marginal dollar is worth more to a poor person than a rich one, modest transfers from the rich to the poor will do the rich little harm but benefit the poor a lot. So, according to this argument, a government that plays Robin Hood, taking from the rich to give to the poor, does more good than harm. Programs that are designed to aid the poor are known as poverty programs.

There is a second major rationale for the welfare state: alleviating economic insecurity. Imagine ten families, each of which can expect an income next year of $50,000 if nothing goes wrong. But suppose the odds are that something will go wrong for one of the families, although nobody knows which one. For example, suppose each of the families has a one in ten chance of experiencing a sharp drop in income because one family member is laid off or incurs large medical bills. And assume that this event will produce severe hardship for the family—a family member will have to drop out of school or the family will lose its home. Now suppose there’s a government program that provides aid to families in distress, paying for that aid by taxing families that are having a good year. Arguably, this program will make all the families better off, because even those families that don’t currently receive aid from the program are likely to need it at some point in the future. Each family will feel safer knowing that the government stands ready to help when disaster strikes. Programs designed to provide protection against unpredictable financial distress are known as social insurance programs.

These two rationales for the welfare state are closely related to the ability-to-pay principle we learned about in Chapter 7. Recall how the ability-to-pay principle is used to justify progressive taxation: it says that people with low incomes, for whom an additional dollar makes a big difference to economic well-being, should pay a
smaller fraction of their income in taxes than people with higher incomes, for whom an additional dollar makes much less difference. The same principle suggests that those with very low incomes should actually get money back from the tax system.

More broadly, as the above For Inquiring Minds explains, some political philosophers argue that principles of social justice demand that society take care of the poor and unlucky. Others disagree, arguing that welfare state programs go beyond the proper role of government. To an important extent, the difference between those two philosophical positions defines what we mean by “liberalism” and “conservatism.”

But before we get carried away, it’s important to realize that things aren’t quite that cut and dried. Even conservatives who believe in limited government typically support some welfare state programs. And even economists who support the goals of the welfare state are concerned about the effects of large-scale aid to the poor and unlucky on their incentives to work and save. Like taxes, welfare state programs can create substantial deadweight losses, so their true economic costs can be considerably larger than the direct monetary cost. We’ll turn to the costs and benefits of the welfare state later in this chapter. First, however, let’s examine the problems the welfare state is supposed to address.

### The Problem of Poverty

For at least the past 70 years, every U.S. president has promised to do his best to reduce poverty. In 1964 President Lyndon Johnson went so far as to declare a “war on poverty,” creating a number of new programs to aid the poor. Antipoverty programs account for a significant part of the U.S. welfare state, although social insurance programs are an even larger part.

But what, exactly, do we mean by poverty? Any definition is somewhat arbitrary. Since 1965, however, the U.S. government has maintained an official definition of the poverty threshold, a minimum annual income that is considered adequate to purchase the necessities of life. Families whose incomes fall below the poverty threshold are considered poor. The history of this official definition is described in the upcoming For Inquiring Minds.

The official poverty threshold depends on the size and composition of a family. In 2007 the poverty threshold for an adult living alone was $10,787; for a household consisting of two adults and two children, it was $21,027.
Trends in Poverty

Contrary to popular misconceptions, although the official poverty threshold is adjusted each year to reflect changes in the cost of living, it has not been adjusted upward over time to reflect the long-term rise in the standard of living of the average American family. As a result, as the economy grows and becomes more prosperous, and average incomes rise, you might expect the percentage of the population living below the poverty threshold to steadily decline.

Somewhat surprisingly, however, this hasn’t happened. Figure 19-1 shows the U.S. poverty rate—the percentage of the population living below the poverty threshold—from 1959 to 2006. As you can see, the poverty rate fell steeply during the 1960s and early 1970s. Since then, however, it has fluctuated up and down, with no clear trend. In fact, in 2006 the poverty rate was higher than it had been in 1973.

Who Are the Poor? Many Americans probably hold a stereotyped image of poverty: an African-American or Hispanic family with no husband present and the female head of the household unemployed at least part of the time. This picture isn’t completely off-base: poverty is disproportionately high among African-Americans.
and Hispanics as well as among female-headed households. But a majority of the poor don’t fit the stereotype.

In 2006, about 36.5 million Americans were in poverty—12.3% of the population, or about one in eight persons. About one-quarter of the poor were African-American and a roughly equal number, Hispanic. Within these two groups, poverty rates were well above the national average: 24.3% of African-Americans and 20.6% of Hispanics. But there was also widespread poverty among non-Hispanic Whites, who had a poverty rate of 8.2%.

There is also a correlation between family makeup and poverty. Female-headed families with no husband present had a very high poverty rate: 30.5%. Married couples were much less likely to be poor, with a poverty rate of only 4.9%; still, about 38% of poor families were married couples.

What really stands out from the data, however, is the association between poverty and lack of adequate employment. Adults who work full time are very unlikely to be poor: only 2.7% of full-time workers were poor in 2006. Adults who worked part time or not at all during the year made up 88.3% of the poor in 2006. Many industries, particularly in the retail and service sectors, now rely primarily on part-time workers. Part-time work typically lacks benefits such as health plans, paid vacation days, and retirement benefits, and it also usually pays a lower hourly wage than comparable full-time work. As a result, many of the poor are members of what analysts call the working poor: workers whose income falls at or below the poverty threshold.

What Causes Poverty? Poverty is often blamed on lack of education, and educational attainment clearly has a strong positive effect on income level—those with more education earn, on average, higher incomes than those with less education. For example, in
1979 the average hourly wage of men with a college degree was 36% higher than that of men with only a high school diploma; by 2006 the “college premium” had increased to 83%. Lack of proficiency in English is also a barrier to higher income. For example, Mexican-born male workers in the United States—two-thirds of whom have not graduated from high school and many of whom have poor English skills—earn less than half of what native-born men earn. And it’s important not to overlook the role of racial and gender discrimination; although less pervasive today than 50 years ago, discrimination still erects formidable barriers to advancement for many Americans. Non-Whites earn less and are less likely to be employed than Whites with comparable levels of education. Studies find that African-American males suffer persistent discrimination by employers in favor of Whites, African-American women, and Hispanic immigrants. Women earn lower incomes than men with similar qualifications.

In addition, one important source of poverty that should not be overlooked is bad luck. Many families find themselves impoverished when a wage-earner loses a job or a family member falls seriously ill.

**Consequences of Poverty** The consequences of poverty are often severe, particularly for children. Currently, more than 17.4% of children in the United States live in poverty. Poverty is often associated with lack of access to health care, which can lead to further health problems that erode the ability to attend school and work later in life. Affordable housing is also frequently a problem, leading poor families to move often, disrupting school and work schedules. Recent medical studies have shown that children raised in severe poverty tend to suffer from lifelong learning disabilities. As a result, American children growing up in or near poverty don’t have an equal chance at the starting line: they tend to be at a disadvantage throughout their lives. For example, even talented children who come from poor families are unlikely to finish college.

Table 19-1 shows the results of a long-term survey conducted by the U.S. Department of Education, which tracked a group of students who were in eighth grade in 1988. That year, the students took a mathematics test that the study used as an indicator of their innate ability; the study also scored students by the socioeconomic status of their families, a measure that took into account their parents’ income and employment. As you can see, the results were disturbing: only 29% of students who were in the highest-scoring 25% on the test but whose parents were of low status finished college. By contrast, the equally talented children of high-status parents had a 74% chance of finishing college—and children of high-status parents had a 30% chance of finishing college even if they had low test scores. What this tells us is that poverty is, to an important degree, self-perpetuating; the children of the poor start at such a disadvantage relative to other Americans that it’s very hard for them to achieve a better life.

**Table 19-1**

<table>
<thead>
<tr>
<th>Mathematics test score</th>
<th>Mathematics test score</th>
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<tbody>
<tr>
<td>in bottom quartile</td>
<td>in top quartile</td>
</tr>
<tr>
<td>Parents in bottom quartile</td>
<td>3%</td>
</tr>
<tr>
<td>Parents in top quartile</td>
<td>29%</td>
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<tr>
<td></td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>74</td>
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</tbody>
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**Economic Inequality**

The United States is a rich country. In 2006, the average U.S. household had an
income of more than $66,000, far exceeding the poverty threshold. How is it possible, then, that so many Americans still live in poverty? The answer is that income is unequally distributed, with many households earning much less than the average and others earning much more.

Table 19-2 shows the distribution of pre-tax income among U.S. families in 2006— income before federal income taxes are paid—as estimated by the Census Bureau. Households are grouped into quintiles, each containing 20% or one-fifth of the population. The first, or bottom, quintile contains households whose income put them below the 20th percentile in income, the second quintile contains households whose income put them between the 20th and 40th percentiles, and so on. The Census Bureau also provides data on the 5% of families with the highest incomes.

For each group, Table 19-2 shows three numbers. The second column shows the range of incomes that define the group. For example, in 2006, the bottom quintile consisted of households with annual incomes of less than $20,032; the next quintile of households with incomes between $20,032 and $37,771; and so on. The third column shows the average income in each group, ranging from $11,352 for the bottom fifth to $297,405 for the top 5 percent. The fourth column shows the percentage of total U.S. income received by each group.

At the bottom of Table 19-2 are two useful numbers for thinking about the incomes of American households. Mean household income, also called average household income, is the total income of all U.S. households divided by the number of households. Median household income is the income of a household in the exact middle of the income distribution—the level of income at which half of all households have lower income and half have higher income. It’s very important to realize that these two numbers do not measure the same thing. Economists often illustrate the difference by asking people first to imagine a room containing several dozen more or less ordinary wage-earners, then to think about what happens to the mean and median incomes of the people in the room if a Wall Street tycoon, some of whom earn more than a billion dollars a year, walks in. The mean income soars, because the tycoon’s income pulls up the average, but median income hardly rises at all. This example helps explain why economists generally regard median income as a better guide to the economic status of typical American families than mean income: mean income is strongly affected by the incomes of a relatively small number of very-high-income Americans, who are not representative of the population as a whole; median income is not.

What we learn from Table 19-2 is that income in the United States is quite unequally distributed. The average income of the poorest fifth of families is less than

### Table 19-2

<table>
<thead>
<tr>
<th>Income group</th>
<th>Income range</th>
<th>Average income</th>
<th>Percent of total income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottom quintile</td>
<td>Less than $20,032</td>
<td>$11,352</td>
<td>3.4%</td>
</tr>
<tr>
<td>Second quintile</td>
<td>$20,032 to $37,771</td>
<td>28,777</td>
<td>8.6</td>
</tr>
<tr>
<td>Third quintile</td>
<td>$37,771 to $60,000</td>
<td>48,223</td>
<td>14.5</td>
</tr>
<tr>
<td>Fourth quintile</td>
<td>$60,000 to $97,030</td>
<td>76,329</td>
<td>22.9</td>
</tr>
<tr>
<td>Top quintile</td>
<td>More than $97,030</td>
<td>168,170</td>
<td>50.5</td>
</tr>
<tr>
<td>Top 5%</td>
<td>More than $174,000</td>
<td>297,405</td>
<td>22.3</td>
</tr>
</tbody>
</table>

Mean income = $66,570  
Median income = $48,201

Source: U.S. Census Bureau.
a quarter of the average income of families in the middle, and the richest fifth have an average income more than three times that of families in the middle. The incomes of the richest fifth of the population are, on average, about 15 times as high as those of the poorest fifth. In fact, the distribution of income in America has become more unequal since 1980, rising to a level that has made it a significant political issue. The Economics in Action at the end of this section discusses long-term trends in U.S. income inequality, which declined in the 1930s and 1940s, was stable for more than 30 years after World War II, but began rising again in the late 1970s.

It’s often convenient to have a single number that summarizes a country’s level of income inequality. The **Gini coefficient**, the most widely used measure of inequality, is based on how disparately income is distributed across the quintiles. A country with a perfectly equal distribution of income—that is, one in which the bottom 20% of the population received 20% of the income, the bottom 40% of the population received 40% of the income, and so on—would have a Gini coefficient of 0. At the other extreme, the highest possible value for the Gini coefficient is 1—the level it would attain if all a country’s income went to just one person.

One way to get a sense of what Gini coefficients mean in practice is to look at international comparisons. Figure 19-2 shows the most recent estimates of the Gini coefficient for many of the world’s countries. Aside from a few countries in Africa, the highest levels of income inequality are found in Latin America, especially Brazil; countries with a high degree of inequality, such as Brazil, have Gini coefficients close to 0.6. The most equal distributions of income are in Europe, especially in Scandinavia; countries with very equal income distributions, such as Sweden, have Gini coefficients around 0.25. Compared to other wealthy countries, the United States, with a Gini coefficient of 0.470 in 2006, has unusually high inequality, though it isn’t as unequal as in Latin America.

How serious an issue is income inequality? In a direct sense, high income inequality means that some people don’t share in a nation’s overall prosperity. As we’ve seen,
rising inequality explains how it’s possible that the U.S. poverty rate has failed to fall for the past 35 years even though the country as a whole has become considerably richer. Also, extreme inequality, as found in Latin America, is often associated with political instability, because of tension between a wealthy minority and the rest of the population.

It’s important to realize, however, that the data shown in Table 19-2 overstate the true degree of inequality in America, for several reasons. One is that the data represent a snapshot for a single year, whereas the incomes of many individual families fluctuate over time. That is, many of those near the bottom in any given year are having an unusually bad year and many of those at the top are having an unusually good one. Over time, their incomes will revert to a more normal level. So a table showing average incomes within quintiles over a longer period, such as a decade, would not show as much inequality. Furthermore, a family’s income tends to vary over its life cycle: most people earn considerably less in their early working years than they will later in life, then experience a considerable drop in income when they retire. Consequently, the numbers in Table 19-2, which combine young workers, mature workers, and retirees, show more inequality than would a table that compares families of similar ages.

Despite these qualifications, there is a considerable amount of genuine inequality in the United States. Moreover, the fact that families’ incomes fluctuate from year to year isn’t entirely good news. Measures of inequality in a given year do overstate true inequality. But those year-to-year fluctuations are part of a problem that worries even affluent families—economic insecurity.

**Economic Insecurity**

As we stated earlier, although the rationale for the welfare state rests in part on the social benefits of reducing poverty and inequality, it also rests in part on the benefits of reducing economic insecurity, which afflicts even relatively well-off families.

One form economic insecurity takes is the risk of a sudden loss of income, which usually happens when a family member loses a job and either spends an extended period without work or is forced to take a new job that pays considerably less. In a given year, according to recent estimates, about one in six American families will see their income cut in half from the previous year. Related estimates show that the percentage of people who find themselves below the poverty threshold for at least one year over the course of a decade is several times higher than the percentage of people below the poverty threshold in any given year.

Even if a family doesn’t face a loss in income, it can face a surge in expenses. The most common reason for such surges is a medical problem that requires expensive treatment, such as heart disease or cancer. Many Americans have health insurance that covers a large share of their expenses in such cases, but a substantial number either do not have health insurance or rely on insurance provided by the government.

**ECONOMICS IN ACTION**

**Long-Term Trends in Income Inequality in the United States**

Does inequality tend to rise, fall, or stay the same over time? The answer is yes—all three. Over the course of the past century, the United States has gone through periods characterized by all three trends: an era of falling inequality during the 1930s and 1940s, an era of stable inequality for about 35 years after World War II, and an era of rising inequality over the past generation.
Detailed U.S. data on income by quintiles, as shown in Table 19-2, are only available starting in 1947. Panel (a) of Figure 19-3 on the next page shows the annual rate of growth of income, adjusted for inflation, for each quintile over two periods: from 1947 to 1980, and from 1980 to 2005. There’s a clear difference between the two periods. In the first period, income within each group grew at about the same rate—that is, there wasn’t much change in the inequality of income, just growing incomes across the board. After 1980, however, incomes grew much more quickly at the top than in the middle, and more quickly in the middle than at the bottom. So inequality has increased substantially since 1980. Overall, inflation-adjusted income for the top quintile rose 60% between 1980 and 2005, but it rose only 3% for the bottom quintile.

Although detailed data on income distribution aren’t available before 1947, economists have instead used other information like income tax data to estimate the share of income going to the top 10% of the population all the way back to 1917. Panel (b) of Figure 19-3 shows this measure from 1917 to 2006. These data, like the more detailed data available since 1947, show that American inequality was more or less stable between 1947 and the late 1970s but has risen substantially since. The longer-term data also show, however, that the relatively equal distribution of 1947 was something new. In the late nineteenth century, often referred to as the Gilded Age, American income was very unequally distributed; this high level of inequality persisted into the 1930s. But inequality declined sharply between the late 1930s and the end of World War II. In a famous paper, Claudia Goldin and Robert Margo, two economic historians, dubbed this narrowing of income inequality “the Great Compression.”

The Great Compression roughly coincided with World War II, a period during which the U.S. government imposed special controls on wages and prices. Evidence
indicates that these controls were applied in ways that reduced inequality—for example, it was much easier for employers to get approval to increase the wages of their lowest-paid employees than to increase executive salaries. What remains puzzling is that the equality imposed by wartime controls lasted for decades after those controls were lifted in 1946.

Since the 1970s, as we’ve already seen, inequality has increased substantially. In fact, pre-tax income appears to be as unequally distributed in America today as it was in the 1920s, prompting many commentators to describe the current state of the nation as a new Gilded Age—albeit one in which the effects of inequality are moderated by taxes and the existence of the welfare state. There is intense debate among economists about the causes of this widening inequality. The most popular explanation is rapid technological change, which has increased the demand for highly skilled or talented workers more rapidly than the demand for other workers, leading to a rise in the wage gap between the highly skilled and other workers. Growing international trade may also have contributed by allowing the United States to import labor-intensive products from low-wage countries rather than making them domestically, reducing the demand for less skilled American workers and depressing their wages. Rising immigration may be yet another source. On average, immigrants have lower education levels than native-born workers and increase the supply of low-skilled labor while depressing low-skilled wages.

All these explanations, however, fail to account for one key feature: much of the rise in inequality doesn’t reflect a rising gap between highly educated workers and those with less education but rather growing differences among highly educated workers themselves. For example, schoolteachers and top business executives have similarly high levels of education, but executive paychecks have risen dramatically and teachers’ salaries have not. For some reason, the economy now pays a few “superstars”—a group that includes literal superstars in the entertainment world but also such groups as Wall Street traders and top corporate executives—much higher incomes than it did a generation ago. It’s still unclear what caused the change.

**CHECK YOUR UNDERSTANDING 19-1**

1. Indicate whether each of the following programs is a poverty program or a social insurance program.
   a. A pension guarantee program, which provides pensions for retirees if they have lost their employment-based pension due to their employer’s bankruptcy
   b. The SCHIP program, which provides health care for children in families that are above the poverty threshold but still have relatively low income
   c. The Section 8 housing program, which provides housing subsidies for low-income households
   d. The federal flood program, which provides financial help to communities hit by major floods

2. Recall that the poverty threshold is not adjusted to reflect changes in the standard of living. As a result, is the poverty threshold a relative or an absolute measure of poverty? That is, does it define poverty according to how poor someone is relative to others or according to some fixed measure that doesn’t change over time? Explain.

3. The accompanying table gives the distribution of income for a very small economy.
   a. What is the mean income? What is the median income?
   b. What income range defines the first quintile? The third quintile?

4. Which of the following statements more accurately reflects the principal source of rising inequality in the United States today?
a. The salary of the manager of the local branch of Sunrise Bank has risen relative to the salary of the neighborhood gas station attendant.
b. The salary of the CEO of Sunrise Bank has risen relative to the salary of the local branch bank manager, who have similar education levels.

Solutions appear at back of book.

The U.S. Welfare State

The U.S. welfare state consists of three huge programs—Social Security, Medicare, and Medicaid—several other fairly big programs, including Temporary Assistance for Needy Families, food stamps, the Earned Income Tax Credit, and a number of smaller programs. Table 19-3 shows one useful way to categorize these programs, along with the amount spent on each listed program in 2005.

First, the table distinguishes between programs that are means-tested and those that are not. In means-tested programs, benefits are available only to families or individuals whose income and/or wealth falls below some minimum. Basically, means-tested programs are poverty programs designed to help only those with low incomes. By contrast, non-means-tested programs provide their benefits to everyone, although, as we'll see, they tend in practice to reduce income inequality.

Second, the table distinguishes between programs that provide monetary transfers that beneficiaries can spend as they choose and those that provide in-kind benefits, which are given in the form of goods or services rather than money. As the numbers suggest, in-kind benefits are dominated by Medicare and Medicaid, which pay for health care. We'll discuss health care in the next section of this chapter. For now, let's examine the other major programs.

Means-Tested Programs

When people use the term welfare, they're often referring to monetary aid to poor families. The main source of such monetary aid in the United States is Temporary Assistance for Needy Families, or TANF. This program does not aid everyone who is poor; it is available only to poor families with children and only for a limited period of time.

TANF was introduced in the 1990s to replace a highly controversial program known as Aid to Families with Dependent Children, or AFDC. The older program was widely accused of creating perverse incentives for the poor, including encouraging family breakup. Partly as a result of the change in programs, the benefits of modern “welfare” are considerably less generous than those available a generation ago, once the data are adjusted for inflation. Also, TANF contains time limits, so welfare recipients—even single parents—must eventually seek work. As you can see from Table 19-3, TANF is a relatively small part of the modern U.S. welfare state.

Other means-tested programs, though more expensive, are less controversial. The Supplemental Security Income program aids disabled Americans who are unable to work and have no other source of income. The food stamp program helps low-income families and individuals, who can use food stamps to buy food staples but not other items.

Finally, economists use the term negative income tax for a program that supplements the earnings of low-income working families. The United States has a program known as the Earned Income Tax Credit (EITC), which provides additional income to millions of workers. It has become more generous as traditional welfare

<table>
<thead>
<tr>
<th>Major U.S. Welfare State Programs, 2005</th>
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<tbody>
<tr>
<td>Monetary transfers</td>
</tr>
<tr>
<td><strong>Means-tested</strong></td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families: $8.9 billion</td>
</tr>
<tr>
<td>Supplemental Security Income: $37.2 billion</td>
</tr>
<tr>
<td>Earned Income Tax Credit: $34.6 billion</td>
</tr>
<tr>
<td><strong>Not means-tested</strong></td>
</tr>
<tr>
<td>Social Security: $518.7 billion</td>
</tr>
<tr>
<td>Unemployment insurance: $31.8 billion</td>
</tr>
</tbody>
</table>

A **means-tested** program is a program available only to individuals or families whose incomes fall below a certain level.

An **in-kind benefit** is a benefit given in the form of goods or services.

A **negative income tax** is a program that supplements the income of low-income working families.
has become less generous. Only workers who earn income are eligible for the EITC; over a certain range of incomes, the more a worker earns, the higher the amount of EITC received. That is, the EITC acts as a negative income tax for low-wage workers. In 2007, married couples with two children earning less than $11,790 per year received EITC payments equal to 40% of their earnings. (Payments were slightly lower for single-parent families or workers without children.) At higher incomes the EITC is phased out, disappearing at an income of $37,783 in 2007.

Social Security and Unemployment Insurance

Social Security, the largest program in the U.S. welfare state, is a non-means-tested program that guarantees retirement income to qualifying older Americans. It also provides benefits to workers who become disabled and “survivor benefits” to family members of workers who die. Social Security is supported by a dedicated tax on wages: the Social Security portion of the payroll tax, which was described in Chapter 7, pays for Social Security benefits. The benefits workers receive on retirement depend on their taxable earnings during their working years: the more you earn up to the maximum amount subject to Social Security taxes ($102,000 in 2008), the more you receive in retirement. Benefits are not, however, strictly proportional to earnings. Instead, they’re determined by a formula that gives high earners more than low earners, but with a sliding scale that makes the program relatively more generous for low earners.

Because most seniors don’t receive pensions from their former employers, and most don’t own enough assets to live off the income from their assets, Social Security benefits are an enormously important source of income for them. Fully 60% of Americans 65 and older rely on Social Security for more than half their income, and 20% have no income at all except for Social Security.

Unemployment insurance, although a much smaller amount of government transfers than Social Security, is another key social insurance program. It provides workers who lose their jobs with about 35% of their previous salary until they find a new job or until 26 weeks have passed. Unemployment insurance is financed by a tax on employers.

The Effects of the Welfare State on Poverty and Inequality

Because the people who receive government transfers tend to be different from those who are taxed to pay for those transfers, the U.S. welfare state has the effect of redistributing income from some people to others. Each year the Census Bureau estimates the effect of this redistribution in a report titled “The Effects of Government Taxes and Transfers on Income and Poverty.” The report calculates only the direct effect of taxes and transfers, without taking into account changes.

<table>
<thead>
<tr>
<th>Group (by age)</th>
<th>Poverty rate without taxes and transfers</th>
<th>Poverty rate with taxes and transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>18.9%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Under 18</td>
<td>20.1</td>
<td>13.0</td>
</tr>
<tr>
<td>18 to 64</td>
<td>14.6</td>
<td>9.9</td>
</tr>
<tr>
<td>65 and over</td>
<td>38.6</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau.
TABLE 19-5

<table>
<thead>
<tr>
<th>Quintiles</th>
<th>Share of aggregate income without taxes and transfers</th>
<th>Share of aggregate income with taxes and transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottom quintile</td>
<td>1.5%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Second quintile</td>
<td>7.3</td>
<td>9.9</td>
</tr>
<tr>
<td>Third quintile</td>
<td>14.0</td>
<td>15.3</td>
</tr>
<tr>
<td>Fourth quintile</td>
<td>23.4</td>
<td>23.1</td>
</tr>
<tr>
<td>Top quintile</td>
<td>53.8</td>
<td>47.3</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau.

in behavior that the taxes and transfers might cause. For example, the report
doesn’t try to estimate how many older Americans who are now retired would still
be working if they weren’t receiving Social Security checks. As a result, the estimates are only a partial indicator of the true effects of the welfare state. Nonetheless, the results are striking.

Table 19-4 shows how taxes and government transfers affected the poverty threshold for the population as a whole and for different age groups in 2005. It shows two numbers for each group: the percentage of the group that would have had incomes below the poverty threshold if the government neither collected taxes nor made transfers, and the percentage that actually fell below the poverty threshold once taxes and transfers were taken into account. (For technical reasons, the second number is somewhat lower than the standard measure of the poverty rate.) Overall, the combined effect of taxes and transfers is to cut the U.S. poverty rate nearly in half. The elderly derived the greatest benefits from redistribution, which reduced their potential poverty rate of 38.6% to an actual poverty rate of 6.7%.

Table 19-5 shows the effect of taxes and transfers on the share of aggregate income going to each quintile of the income distribution in 2005. Like Table 19-4, it shows both what the distribution of income would have been if there were no taxes or government transfers, and the actual distribution of income taking into account both taxes and transfers. The effect of government programs was to increase the share of income going to the poorest 60% of the population, especially the share going to the poorest 20%, while reducing the share of income going to the richest 20%.

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**ECONOMICS IN ACTION**

**Britain’s War on Poverty**

Between 1979 and 1997, Britain, like the United States, experienced a substantial increase in inequality. Britain doesn’t have any single official definition of poverty, but the measure that most closely approximates the U.S. measurement of the poverty threshold indicates that poverty in Britain fell only slightly between 1979 and the mid-1990s even though average income rose substantially.

In 1997, however, control of Britain’s government switched from the Conservative Party, which generally sought to limit the size of Britain’s welfare state, to the Labour Party, which promised to reduce poverty and inequality. In its efforts to accomplish this, Britain’s Labour government has adopted policies that include child benefits paid to every family with children and a “work benefit” that is similar to the U.S. Earned Income Tax Credit but considerably more generous.

As panel (a) of Figure 19-4 shows, the effects of these policies on British poverty have been impressive: the British poverty measure that corresponds most closely to
the U.S. measure shows that the poverty rate was cut in half between 1997 and 2005, though it has since risen again slightly. The British government is frustrated, however, that its policies don’t seem to have helped a persistent underclass of the very poor.

The effect of Labour’s policy on overall inequality is less clear. Panel (b) of Figure 19-4 shows Britain’s Gini coefficient, which rose sharply in the 1980s and has since stabilized but not fallen significantly. As in the United States, but not to the same degree, the incomes of the top 1% of the population have been rising much faster than everyone else’s. Sources: U.K. Department for Work and Pensions (panel (a)). U.K. Office for National Statistics (panel (b)).

> **CHECK YOUR UNDERSTANDING 19-2**

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 19-4, 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

A 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 19-5 on the next page shows who paid for U.S. health care in 2006. Only 12% of medical bills were paid “out of pocket”—that is, paid directly by individuals. A much larger share, 46%, was paid by the government, mainly through Medicare and Medicaid. About 34% was paid by private insurance companies, with the remaining 7% coming mainly from charities. To understand this pattern, we need to examine the special economics of health care.

The Need for Health Insurance

In 2006, U.S. personal health care expenses were $7,026 per person—16% of gross domestic product. This did not, however, mean that the typical American spent just over $7,000 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. In 2002, 20% of the U.S. population accounted for 80% of the medical costs, and 5% of the population accounted for almost half the 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.

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 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 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 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 insurance. The policy would be a bad deal for healthy people, who don’t face a large 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 would probably decide to take their chances and go without insurance; as a result, the insurance company’s customers would be less healthy than the average American, which would raise the company’s costs per customer. That is, the insurance company would face a problem called *adverse selection*, which is analyzed in greater detail in Chapter 21. Because of adverse selection, a company that tried to offer health insurance to everyone at a price reflecting average medical costs 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*.

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 by carefully screening people who apply for coverage, charging people who are likely to have high medical expenses higher-than-average premiums—or, in many cases, refusing to cover them at all. 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. As long as healthy employees are not allowed to opt out, there are typically enough healthy employees to help subsidize the cost of less-healthy employees.

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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 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.
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 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; and the unemployed.

**Government Health Insurance**

Table 19-6 shows the breakdown of health insurance coverage across the U.S. population in 2006. Most Americans, more than 177 million people, received health insurance through employers. The majority of those who didn’t have 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 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—$15,696—with average annual Medicare payments per recipient, which were more than $8,000 (2006 data). (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.)

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. 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 38.3 million Americans covered by Medicaid in 2006, 20.1 million were children under 18, and many of the rest were parents of children under 18. (The SCHIP program, which we described in the opening story, is counted in these numbers as part of Medicaid.) Most of the cost of Medicaid, however, is accounted for by a small number of older Americans, especially those needing long-term care.

In addition to the 79 million Americans covered by Medicare and Medicaid, nearly 11 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 4.4 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, 47 million people in America, 15.8% of the population, have 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, 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. 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

![Figure 19-6: The Consequences of Being Uninsured](image_url)

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.

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 19-6 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 financial 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.

### 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 19-7 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. 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 basically 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: 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 sys-

<table>
<thead>
<tr>
<th>Health Care Systems in Advanced Countries (2005 data unless indicated)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government share of health care spending</strong></td>
</tr>
<tr>
<td>United States</td>
</tr>
<tr>
<td>Canada</td>
</tr>
<tr>
<td>France</td>
</tr>
<tr>
<td>Britain</td>
</tr>
</tbody>
</table>

*2004 data  
tems 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 large differences in the quality of care received by patients in Canada, Europe, and the United States. And as Table 19–7 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 ways that don’t show up in either surveys of patient experiences or statistics on health performance. Another possibility 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. The United States also pays higher prices for prescription drugs, because in other countries government agencies bargain with pharmaceutical companies to get lower drug prices.

The Health Care Crisis and Proposals for Reform

Whatever one thinks of the past performance of the U.S. health care system, that system is clearly in trouble today. The root of the problem is the rising cost of health insurance, whether private or public.

For one thing, the cost of private insurance has risen much faster than incomes. For example, between 2001 and 2007 the average premiums for employment-based

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**FIGURE 19-7**

Changes in Health Insurance Status, 2000–2006

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 and SCHIP, made up part of the difference. There has also, however, been an increase in the number of uninsured.

Source: U.S. Census Bureau.
health insurance rose 78%, but the wages of the average worker rose only 19%. By 2007, the average cost of insurance for a family of four was more than $12,000.

As a result of these rising costs, employment-based health insurance, the centerpiece of the system for Americans under 65, is in decline. Figure 19-7 shows selected changes in the insurance status of Americans between 2000 and 2006. Over that period, the total population rose by 17 million. But the number of people with employment-based health insurance not only failed to keep up with population growth—it declined by more than 2 million. However, more people were covered by government programs, mainly due to an expansion of Medicaid. But this expansion did not keep up with population growth, and more than 8 million people joined the ranks of the uninsured.

Even as private health insurance seems to be faltering and the number of Americans without health insurance is rising, 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.

What’s behind these rising costs? Figure 19-8 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.

But 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 at great expense. The upcoming Economics in Action gives some examples. 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
The Cost of Medical Progress, 1970–2004

Three areas in which treatment has grown enormously over time are coronary disease, which was more or less untreatable until the late 1960s; kidney failure, which has become treatable via dialysis; and the replacement of failing joints. All these new medical procedures do a great deal of good but also cost a great deal of money.

Source: Congressional Budget Office; Department of Health and Human Services; National Center for Health Statistics.
just how the process works. Figure 19-9 shows the growth in expensive treatments for a few major medical problems that, not too long ago, couldn’t be treated at all.

- **Coronary artery disease.** “In the 1950s and much of the 1960s,” writes the CBO, “caring for patients with coronary artery disease was inexpensive because physicians could do little to help them.” But then came the development of open-heart surgery and other techniques such as angioplasty. The result is that many heart-disease patients who might have died receive a second lease on life—but at huge expense.

- **Kidney failure.** “Until techniques and devices were developed that could perform the waste-removing functions of the kidneys (renal replacement therapy),” writes the CBO, “patients who suffered severe kidney failure tended to die quickly.” Now they can be kept alive for years thanks to dialysis—again, at great expense.

- **Joint problems.** In the past, joint problems, which can often be crippling, simply had to be suffered. Now, however, it’s common to receive hip and knee replacement, a tremendous gain—but again, at great expense.

Medical progress is a wonderful thing. But as we’ve seen, the growing cost of health care is causing severe strains on both private and public health insurance, both in the United States and in the rest of the world. It remains to be seen how the tension between what doctors can do and what society can afford will be resolved.

### CHECK YOUR UNDERSTANDING 19-3

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 by requiring all students to join and pay premiums.

2. According to its critics, what partly accounts for the higher costs of the U.S. health care system compared to 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, protect everyone from financial risk, and ensure that people can afford 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 reflects differences in philosophy but also reflects concern about the possibly counterproductive effects of welfare state programs. Disputes about the size of the welfare state are also one of the defining issues of modern politics.

### Problems with the Welfare State

There are two different lines of argument 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—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 arose in Chapter 7 when we discussed the case for progressive taxation. 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—suggests 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 there are efficiency arguments against making marginal tax rates too high. 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, as we explained in Chapter 7, the design of the tax system involves a trade-off between equity and efficiency.

A similar trade-off between equity and efficiency is an argument against having too extensive a welfare state. A government that operates a large welfare state requires more revenue than one that limits itself mainly to provision of public goods such as national defense. So nations that have a large welfare state must have higher tax revenue, and higher marginal tax rates, than countries with a small welfare state. Table 19-8 shows “social expenditure,” a measure that roughly corresponds to 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 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.

The trade-off between a large welfare state and high marginal tax rates seems to suggest that we should try to hold down the cost of the welfare state. One way to do this is to means-test benefits: make them available only to those who need them. But means-testing, it turns out, 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 family member is deciding whether to take a new job that will raise the family’s income to $20,500. Well, taking that job will actually make the family worse off, because it will gain $1,000 in earnings but lose the $2,000 government benefit.

This situation, in which earning more actually leaves a family worse off through lost benefits, is known as a notch. It is a well-known problem with programs that aid the poor and behaves much like a high marginal tax rate on income. Most welfare state programs are designed to avoid creating a notch. This is typically done by setting a sliding scale for benefits such that they fall off gradually as the recipient’s income rises rather than come to an abrupt end. Even so, the combined effects of the major means-tested programs shown in Table 19-3, plus additional means-tested programs such as housing aid that are offered by some state and local governments, can be to create very high effective marginal tax rates. For example, one 2005 study found that a family consisting of two adults and two children that raised its income from $20,000 a year—just above the poverty threshold in 2005—to $35,000 would

<table>
<thead>
<tr>
<th>Social expenditure in 2003 (percent of GDP)</th>
<th>Marginal tax rate in 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>18.6%</td>
</tr>
<tr>
<td>Britain</td>
<td>22.1%</td>
</tr>
<tr>
<td>France</td>
<td>29.4%</td>
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</tbody>
</table>

Sources: OECD Social Expenditure Database; OECD Taxing Wages Database.
find almost all its increase in after-tax income offset by loss of benefits such as food stamps, the Earned Income Tax Credit, and Medicaid.

**The Politics of the Welfare State**

In 1791, in the early phase of the French Revolution, France had a sort of congress, the National Assembly, in which representatives were seated according to social class: nobles, who pretty much liked the way things were, sat on the right; commoners, who wanted big changes, sat on the left. Ever since, it has been common in political discourse to talk about politicians as being on the “right” (more conservative) or on the “left” (more liberal).

But what do modern politicians on the left and right disagree about? In the modern United States, they mainly disagree about the appropriate size of the welfare state. For example, as we mentioned in the opening story, SCHIP, which provides children with health insurance, was created in 1997 with bipartisan support. But in 2007 there was a fierce political debate over whether to expand the program.

You might think that saying that political debate is really about just one thing—how big to make the welfare state—is a huge oversimplification. But political scientists have found that once you carefully rank members of Congress from right to left, a congressperson’s position in that ranking does a very good job of predicting his or her votes on proposed legislation. Modern politics isn’t completely one-dimensional—but it comes pretty close.

The same studies that show a strong left–right spectrum in U.S. politics also show strong polarization between the major parties on this spectrum. Thirty years ago there was a substantial overlap between the parties: some Democrats were to the right of some Republicans, or, if you prefer, some Republicans were to the left of some Democrats. Today, however, the rightmost Democrats appear to be to the left of the leftmost Republicans. There’s nothing necessarily wrong with this. Although it’s common to decry “partisanship,” it’s hard to see why members of different political parties shouldn’t have different views about policy.

Can economic analysis help resolve this political conflict? Only up to a point.

Some of the political controversy over the welfare state involves differences in opinion about the trade-offs we have just discussed: if you believe that the disincentive effects of generous benefits and high taxes are very large, you’re likely to look less favorably on welfare state programs than if you believe they’re fairly small. Economic analysis, by improving our knowledge of the facts, can help resolve some of these differences.

To an important extent, however, differences of opinion on the welfare state reflect differences in values and philosophy. And those are differences economics can’t resolve.

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**ECONOMICS IN ACTION**

**French Family Values**

The United States has the smallest welfare state of any major advanced economy. France has one of the largest. As we’ve already described, France has much higher social spending than America as a percentage of total national income, and French citizens face much higher tax rates than Americans. One argument against a large welfare state is that it has negative effects on efficiency. Does French experience support this argument?

On the face of it, the answer would seem to be a clear yes. French GDP per capita—the total value of the economy’s output, divided by the total population—is only
72% of the U.S. level. This reflects the fact that the French work less: French workers and U.S. workers have almost exactly the same productivity per hour, but a smaller fraction of the French population is employed, and the average French employee works substantially fewer hours over the course of a year than his or her American counterpart. Some economists have argued that high tax rates in France explain this difference: the incentives to work are less in France than in the United States, because the government takes away so much of what you earn from an additional hour of work.

A closer examination, however, reveals that the story is more complicated than that. The low level of employment in France is entirely the result of low rates of employment among the young and the old; 80% of French residents of prime working age, 25–54, are employed, exactly the same percentage as in the United States. So high tax rates don’t seem to discourage the French from working in the prime of their lives. And young people in France don’t work in part because they don’t have to: college education is generally free, and students receive financial support, so French students, unlike their American counterparts, rarely work while attending school. The French will tell you that that’s a virtue of their system, not a problem.

Shorter working hours also reflect factors besides tax rates. French law requires employers to offer at least a month of vacation, but most U.S. workers take less than two weeks off. Here, too, the French will tell you that their policy is better than ours, because it helps families spend time together.

The aspect of French policy even the French agree is a big problem is that their retirement system allows workers to collect generous pensions even if they retire very early. As a result, only 40% of French residents between the ages of 55 and 64 are employed, compared with more than 60% in America. The cost of supporting all those early retirees is a major burden on the French welfare state—and getting worse as the French population ages.

**CHECK YOUR UNDERSTANDING 19-4**

1. Explain how each of the following policies creates a disincentive to work or undertake a risky investment.
   - a. A high sales tax on consumer items
   - b. The loss of a housing subsidy when yearly income rises above $25,000

2. Over the past 30 years, has the polarization in Congress increased, decreased, or stayed the same?

Solutions appear at back of book.
1. The welfare state absorbs a large share of government spending in all wealthy countries. Government transfers are the payments made by the government to individuals and families. Poverty programs alleviate income inequality by helping the poor; social insurance programs alleviate economic insecurity.

2. Despite the fact that the poverty threshold is adjusted according to the cost of living but not according to the standard of living, and that the average American income has risen substantially over those 30 years, the poverty rate, the percentage of the population with an income below the poverty threshold, is no lower than it was 30 years ago. There are various causes of poverty: lack of education, the legacy of discrimination, and bad luck. The consequences of poverty are particularly harmful for children.

3. Median household income, the income of a family at the center of the income distribution, is a better indicator of the income of the typical household than mean household income because it is not distorted by the inclusion of a small number of very wealthy households. The Gini coefficient, a number that summarizes a country’s level of income inequality based on how unequally income is distributed across quintiles, is used to compare income inequality across countries.

4. Both means-tested and non-means-tested programs reduce poverty. The major in-kind benefits programs are Medicare and Medicaid, which pay for medical care. Due to concerns about the effects on incentives to work and on family cohesion, aid to poor families has become significantly less generous even as the negative income tax has become more generous. Social Security, the largest U.S. welfare state program, has significantly reduced poverty among the elderly. Unemployment insurance is also a key social insurance program.

5. Health insurance satisfies an important need because most families cannot afford expensive medical treatment. Private health insurance, unless it is employment-based, has the potential to fall into an adverse selection death spiral. Most Americans are covered by employment-based private health insurance; most of the remaining are covered by Medicare (for those over 65) or Medicaid (for those with low incomes).

6. Compared to other countries, the United States relies more heavily on private health insurance and has substantially higher health care costs per person without providing better care. Some countries have a single-payer system, a system in which the government pays most medical bills, funded through taxes.

7. Debates over the size of the welfare state are based on philosophical and equity-versus-efficiency considerations. Although high marginal tax rates to finance an extensive welfare state can reduce the incentive to work, means-testing programs in order to reduce the cost of the welfare state also reduce the incentive to work.

8. Politicians on the left tend to favor a bigger welfare state and those on the right oppose it. This left–right distinction is central to today’s politics. America’s two major political parties have become more polarized in recent decades, with a much clearer distinction than in the past about where their members stand on the left-right spectrum.

**SUMMARY**

**KEY TERMS**

- Welfare state, p. 480
- Government transfer, p. 480
- Poverty program, p. 480
- Social insurance programs, p. 480
- Poverty threshold, p. 481
- Poverty rate, p. 482
- Mean household income, p. 485
- Median household income, p. 485
- Gini coefficient, p. 486
- Means-tested, p. 490
- Negative benefit, p. 490
- Negative income tax, p. 490
- Private health insurance, p. 494
- Single-payer system, p. 498

**PROBLEMS**

1. The accompanying table contains data on the U.S. economy for the years 1983 and 2006. The second column shows the poverty threshold. The third column shows the consumer price index (CPI), a measure of the overall level of prices. And the fourth column shows U.S. gross domestic product (GDP) per capita, a measure of the standard of living.

<table>
<thead>
<tr>
<th>Year</th>
<th>Poverty threshold</th>
<th>CPI (1982–1984 = 100)</th>
<th>GDP per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983</td>
<td>$5,180</td>
<td>99.6</td>
<td>$15,092</td>
</tr>
<tr>
<td>2006</td>
<td>10,488</td>
<td>201.6</td>
<td>44,007</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau; Bureau of Labor Statistics; Bureau of Economic Analysis.
a. By what factor has the poverty threshold increased from 1983 to 2006? That is, has it doubled, tripled, and so on?

b. By what factor has the CPI (a measure of the overall price level) increased from 1983 to 2006? That is, has it doubled, tripled, and so on?

c. By what factor has GDP per capita (a measure of the standard of living) increased from 1983 to 2006? That is, has it doubled, tripled, and so on?

d. What do your results tell you about how those people officially classified as “poor” have done economically relative to other U.S. citizens?

2. In the city of Metropolis, there are 100 residents, each of whom lives until age 75. Residents of Metropolis have the following incomes over their lifetime: through age 14, they earn nothing. From age 15 until age 29, they earn 200 metros (the currency of Metropolis) per year. From age 30 to age 49, they earn 400 metros. From age 50 to age 64, they earn 300 metros. Finally, at age 65 they retire and are paid a pension of 100 metros per year until they die at age 75. Each year, everyone consumes whatever their income is that year (that is, there is no saving and no borrowing). Currently, 20 residents are 10 years old, 20 residents are 20 years old, 20 residents are 40 years old, 20 residents are 60 years old, and 20 residents are 70 years old.

a. Study the income distribution among all residents of Metropolis. Split the population into quintiles according to their income. How much income does a resident in the lowest quintile have? In the second, third, fourth, and top quintiles? Which share of total income of all residents goes to the residents in each quintile? Construct a table showing the share of total income that goes to each quintile. Does this income distribution show inequality?

b. Now look only at the 20 residents of Metropolis who are currently 40 years old, and study the income distribution among only those residents. Split those 20 residents into quintiles according to their income. How much income does a resident in the lowest quintile have? In the second, third, fourth, and top quintiles? Which share of total income of all residents goes to the residents in each quintile? Does this income distribution show inequality?

c. What is the relevance of these examples for assessing data on the distribution of income in any country?

3. The accompanying table presents data from the U.S. Census Bureau on median and mean income of male workers for the years 1972 and 2005. The income figures are adjusted to eliminate the effect of inflation.

<table>
<thead>
<tr>
<th>Year</th>
<th>Median income (in 2005 dollars)</th>
<th>Mean income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1972</td>
<td>$42,617</td>
<td>$47,708</td>
</tr>
<tr>
<td>2005</td>
<td>42,188</td>
<td>58,779</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau.

a. By what percentage has median income changed over this period? By what percentage has mean income changed over this period?

b. Between 1972 and 2005, has the income distribution become less or more unequal? Explain.

4. There are 100 households in the economy of Equalor. Initially, 99 of them have an income of $10,000 each, and one household has an income of $1,010,000.

a. What is the median income in this economy? What is the mean income?

b. What is the median income in this economy now? What is the mean income? Has the median income changed? Has the mean income changed? Which indicator (mean or median household income) is a better indicator of the typical Equalorian household’s income? Explain.

5. The country of Marxland has the following income tax and social insurance system. Each citizen’s income is taxed at an average tax rate of 100%. A social insurance system then provides transfers to each citizen such that each citizen’s after-tax income is exactly equal. That is, each citizen gets (through a government transfer payment) an equal share of the income tax revenue. What is the incentive for one individual citizen to work and earn income? What will the total tax revenue in Marxland be? What will be the after-tax income (including the transfer payment) for each citizen? Do you think such a tax system that creates perfect equality will work?

6. The tax system in Taxilvania includes a negative income tax. For all incomes below $10,000, individuals pay an income tax of −40% (that is, they receive a payment of 40% of their income). For any income above the $10,000 threshold, the tax rate on that additional income is 10%. For the first three scenarios below, calculate the amount of income tax to be paid and after-tax income.

a. Lowani earns income of $8,000.

b. Midram earns income of $40,000.

c. Hi-Wan earns income of $100,000.

d. Can you find a notch in this tax system? That is, can you find a situation where earning more pre-tax income actually results in less after-tax income?

7. In the city of Notchingham, each worker is paid a wage rate of $10 per hour. Notchingham administers its own unemployment benefit, which is structured as follows: if you are unemployed (that is, if you do not work at all), you get unemployment benefits (a transfer from the government) of $50 per day. As soon as you work for only one hour, the unemployment benefit is completely withdrawn. That is, there is a notch in the benefit system.

a. How much income does an unemployed person have per day? How much daily income does an individual have who works four hours per day? How many hours do you need to work to earn just the same as if you were unemployed?

b. Will anyone ever accept a part-time job that requires working four hours per day, rather than being unemployed?
c. Suppose that Notingham now changes the way in which the unemployment benefit is withdrawn. For each additional dollar an individual earns, $0.50 of the unemployment benefit is withdrawn. How much daily income does an individual who works four hours per day now have? Is there an incentive now to work four hours per day rather than being unemployed?

8. In a private insurance market, there are two different kinds of people: some who are more likely to require expensive medical treatment and some who are less likely to require medical treatment and who, if they do, require less expensive treatment. One health insurance policy is offered, tailored to the average person's health care needs: the premium is equal to the average person's medical expenses (plus the insurer's expenses and normal profit).
   a. Explain why such an insurance policy is unlikely to be feasible.
   In an effort to avoid the adverse selection death spiral, a private health insurer offers two health insurance policies: one that is intended for those who are more likely to require expensive treatment (and therefore charges a higher premium) and one that is intended for those who are less likely to require treatment (and therefore charges a lower premium).
   b. Could this system overcome the problem created by adverse selection?
   c. How does the British National Health Service (NHS) avoid these problems?

9. The accompanying table shows data on the total number of people in the United States and the number of all people who were uninsured, for selected years from 1997 to 2005. It also shows data on the total number of poor children in the United States—those under 18 and below the poverty threshold—and the number of poor children who were uninsured.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total people (millions)</th>
<th>Uninsured people</th>
<th>Total poor children</th>
<th>Uninsured poor children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>269.1</td>
<td>43.4</td>
<td>14.1</td>
<td>3.4</td>
</tr>
<tr>
<td>1999</td>
<td>276.8</td>
<td>40.2</td>
<td>12.3</td>
<td>2.8</td>
</tr>
<tr>
<td>2001</td>
<td>282.1</td>
<td>41.2</td>
<td>11.7</td>
<td>2.5</td>
</tr>
<tr>
<td>2003</td>
<td>288.3</td>
<td>45.0</td>
<td>12.9</td>
<td>2.5</td>
</tr>
<tr>
<td>2005</td>
<td>293.8</td>
<td>46.6</td>
<td>12.9</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau.

For each year, calculate the percentage of all people who were uninsured and the percentage of poor children who were uninsured. How have these percentages changed over time? What is a possible explanation for the change in the percentage of uninsured poor children?

10. The American National Election Studies conducts periodic research on the opinions of U.S. voters. The accompanying table shows the percentage of people, in selected years from 1952 to 2004, who agreed with the statement “There are important differences in what the Republicans and Democrats stand for.”

<table>
<thead>
<tr>
<th>Year</th>
<th>Agree with statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1952</td>
<td>50%</td>
</tr>
<tr>
<td>1972</td>
<td>46</td>
</tr>
<tr>
<td>1992</td>
<td>60</td>
</tr>
<tr>
<td>2004</td>
<td>76</td>
</tr>
</tbody>
</table>

Source: American National Election Studies.

What do these data say about the degree of partisanship in U.S. politics over time?