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# Universal Coverage in the United States: Lessons From Experience of the 20th Century

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**ABSTRACT** *Both the rising numbers of uninsured Americans and the recent presidential election have put the issue of universal health insurance coverage back on the national agenda. Lack of health insurance is a major barrier to care for 44 million Americans, and lack of high-quality, comprehensive insurance is a barrier to millions more. Universal coverage is one of the best ways to ensure that all Americans have equitable access to quality care, and it also contributes to the financial stability of health care providers, especially those in the urban safety net. A wide variety of ideas to expand health care coverage were proposed, and in some cases enacted, during the last century. At the beginning of the 21st century, the American health care system is made up of varied elements, ranging from employer-sponsored health insurance for the majority of working-age adults to the public Medicare program for the elderly. While this patchwork system leaves many Americans without health insurance, it also creates many different ways to expand coverage, including various options in both the private and public sectors. By understanding how the current health care system developed, how the various proposals for universal health coverage gained and lost political and public support, and the pros and cons of the various alternatives available to expand coverage, we create a solid base from which to solve the problem of the uninsured in the 21st century.*

The single greatest barrier to ensuring equitable access to health care in the United States is the absence of universal health insurance coverage. The United States is the only major industrialized nation without universal health insurance coverage; as a result, it experiences greater differentials in access to care by income than other industrialized countries.[1] The absence of universal health insurance coverage is one of the great unsolved problems facing the nation at the onset of the 21st century. It has serious consequences for the 44 million uninsured Americans—their health, access to care, preventive care, and quality of care—as well as for those with inadequate health insurance.[2] For example, those who are uninsured or have gaps in insurance coverage are more likely not to have a regular doctor (53% vs. 18%) or not to have received any preventive services in the past year (45% vs. 23%) than the continuously insured.[3] The Commonwealth Fund 1999 National Survey of Workers' Health Insurance[4] found that 49% of the uninsured report they did not see a doctor when needed, did not fill a prescription due to cost, or skipped a medical test or treatment due to cost compared with 18% of the insured. The uninsured are also more likely to be somewhat or very dissatisfied with the quality of medical care they receive (25% vs. 13%).[4]

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Fiscal pressures on the health sector are likely to make it increasingly difficult for uninsured and underinsured Americans to receive free or low-cost care, and the absence of universal coverage will contribute to financial instability in the health care sector for urban safety net health care providers. Making a commitment to universal coverage and garnering consensus on an effective mechanism for doing so is necessary to ensure a health care system that provides quality care to all. It needs to be a top priority for the nation in the 21st century.

## EFFORTS TO ACHIEVE UNIVERSAL COVERAGE IN THE 20TH CENTURY

Although Americans saw a wide variety of proposals to ensure universal health insurance coverage during the 20th century, only coverage for the elderly, the disabled, low-income children, and selected adults was enacted. Theodore Roosevelt endorsed health insurance modeled on workmen's compensation in his 1912 bid for the Presidency[5] (Fig. 1). President Harry Truman delivered a stirring presidential message on November 19, 1945, that called for adding universal health insurance to Social Security[6]; his plan was the core of various Wagner-Murray-Dingell bills introduced in the late 1940s. President Eisenhower supported small-business risk pools and other market reforms in 1956.

President John F. Kennedy made Medicare a major election issue in 1960, and President Lyndon B. Johnson signed Medicare and Medicaid into law on July 30, 1965.[7] President Richard Nixon proposed a Comprehensive Health Insurance Plan that received serious legislative consideration in 1974.[8] The central feature of the plan was employer-mandated private insurance coverage for workers and their families in firms with 25 or more employees, a plan for low-income families that would replace and improve Medicaid, and a federal health insurance plan that would replace and improve Medicare.

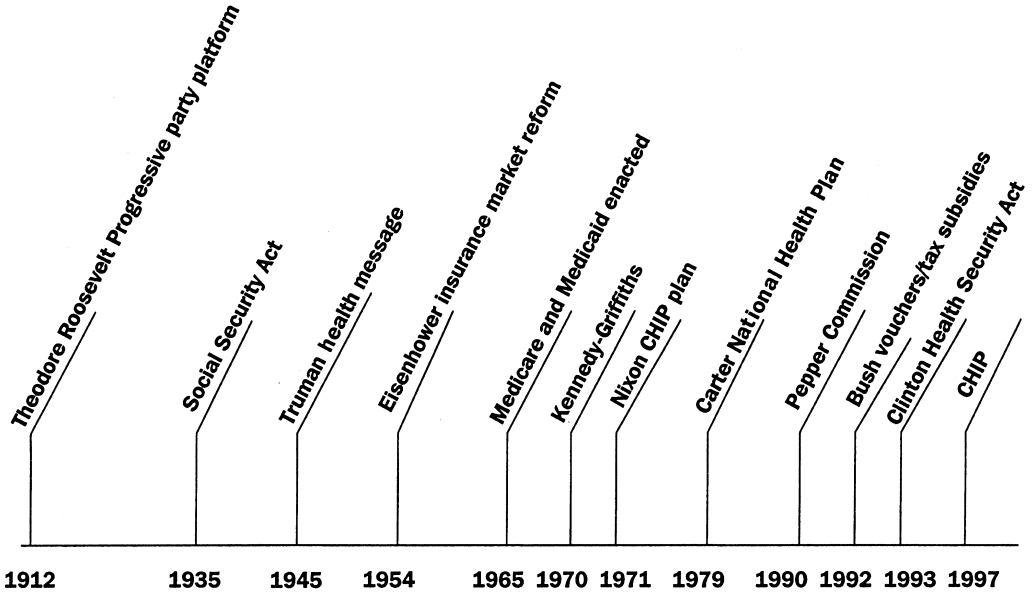


**FIGURE 1.** Milestones in national health insurance proposals, 1912–1997.

President Jimmy Carter's National Health Plan represented an incremental approach to phased-in health insurance coverage. It included an employer-mandated set of minimum standards on benefits and employer contributions and a new federal HealthCare program to replace Medicaid and Medicare and cover all low-income individuals in addition to the elderly and disabled.[9] President George Bush advanced a health insurance proposal in February 1992, including vouchers for the poor to purchase private health insurance and tax credits or deductions for families with incomes up to $80,000, as well as the creation of small-business pools and health insurance networks.[10]

The 1990 Pepper Commission, chaired by Senator Jay Rockefeller, narrowly approved a "pay or play" approach to employer coverage; either employers could play by providing health insurance to workers voluntarily or pay a payroll tax to have their workers and dependents covered under a public plan.[11] This was translated into the HealthAmerica legislative proposal introduced by Senator George Mitchell with bipartisan support. Employers were required to pay 80% of premiums for full-time workers and 50% of premiums for part-time workers. The state-administered public AmeriCare plan provided comprehensive coverage with no cost-sharing for everyone with incomes below the poverty level.

A Democratically controlled Congress and the newly elected Democratic President Bill Clinton committed to renew serious legislative consideration to national health insurance in 1993–1994. The Clinton Health Security Act included an employer mandate that required employers to pay 80% of the premium (up to a maximum of 7.9% of payroll), with the family share of premiums not to exceed 3.9% of income.[12] The plan was to be financed by substantial Medicare and Medicaid savings, an increase in tobacco taxes, and cross subsidies among employers within risk pools.

Because of the failure to enact these proposals, health policy has shifted focus to incremental approaches to health insurance coverage. The Kassebaum-Kennedy Health Insurance Portability and Accountability Act of 1996 prohibited pre-existing condition clauses for those changing employer coverage. It also included a small-scale demonstration of medical savings accounts.

In 1997, the Balanced Budget Act included a state Children's Health Insurance Plan (CHIP) that provided federal matching funds to expand coverage to children in families with incomes up to 200% of the federal poverty level. The expanded coverage was financed by an increase in the tobacco tax. An estimated 2 to 3 million uninsured children are expected to be covered when CHIP is implemented fully.

## LESSONS FOR THE 21ST CENTURY

Throughout the 20th century, health insurance coverage surfaced as a major public policy issue—only to encounter significant dissension among advocates about the best approach and opposition from those interests threatened by change. The poor, minorities, and uninsured are those most disadvantaged by the health system but are least able to advocate for change. Providing universal coverage also requires a redistribution of resources from those who are better off and have little to gain from expanded coverage.

While health care was on the national agenda throughout the century, the focus changed over time. Early in the 20th century, a newly industrialized nation was concerned about lost labor productivity when illness or injury undermined the ability to work. In the aftermath of the Great Depression, the economic ruin that major

health care expenses could bring to uninsured families was paramount. Following World War II, the mortality from preventable disease and breakthroughs in medical research pointed to health gains for the nation that could come from greater investment in health.

The growth of employer-based private health insurance and the breakdown of private coverage for those who retired or were chronically ill set the stage for Medicare. Rising health costs focused both Republican and Democratic Presidents (Nixon and Carter) on national health insurance as a mechanism for both controlling costs and ensuring equitable access to health care services.

More recently, health reform proposals have shifted emphasis somewhat from concern with equity and access to care to a focus on economic incentives in the health care system and how to change them to induce greater efficiency. President Clinton tried to provide a legislative framework for the evolution of managed care—ensuring choice, quality, access, and cost control through managed competition and purchasing coalitions.

In each era, political obstacles to the enactment of universal coverage blocked progress. Major reform efforts sometimes faltered because providers of health services and health insurers felt threatened economically. At other times, proposals foundered from events external to health care—outbreak of war, budgetary deficits, or political division. As employers have become the main source of health insurance, the nation also became increasingly divided between those with coverage and those without; this required new taxes or a redistribution of income of those who did not stand to benefit to finance coverage for low-income uninsured individuals.

But, important incremental changes did occur: Medicare and Medicaid in 1965 and children's health insurance in 1997. The private sector has evolved; employer-based health insurance expanded dramatically following World War II, and managed care has come to dominate employer coverage in the 1990s.

At the beginning of the 21st century, the forces conducive to change include broad public concern about health care coupled with relatively good economic prosperity. Incremental change that does little to change the organization and delivery of services has fared better than more sweeping health care reform proposals that would have a substantial impact on the economic interests of health care providers or insurers.

## CURRENT DIRECTION

The absence of health insurance coverage is a serious and growing problem. In 1998, there were 44.3 million Americans who were uninsured.[13] About one-fourth of Americans receive coverage under Medicare and Medicaid. Health insurance coverage voluntarily provided by employers, however, is the mainstay of American health insurance coverage. About 60% of all Americans, 155 million people, obtain health insurance through employer-sponsored coverage.

Each year, the number of uninsured rises by about 1 million people. Since this has been true for almost 20 years, it is easy to forget that it has not always been the case. Between 1953 and 1976, the number of uninsured dropped from 71 million people to 23 million people—or from 44% of the total population to 11% (Fig. 2). The growth of employer-provided health insurance was the major factor driving down the number of uninsured individuals in the 1950s and early 1960s. The enactment of Medicare and Medicaid in 1965 was the major reason for the rapid decline between the mid-1960s and mid-1970s.

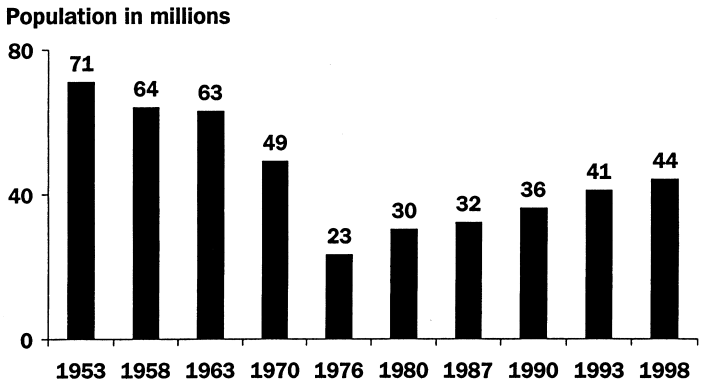


**FIGURE 2.** Growth in the number of uninsured, 1953–1998. (*Source:* 1953–1976, National Health Interview Survey; 1980–1997, Employee Benefits Research Institute; 1998, March 1999 Current Population Survey.)

The reasons for the rise in the numbers of uninsured since the mid-1970s is less well understood. The most commonly cited reason is the rise in health insurance premiums, which has made coverage less affordable for employers and for individuals. This undoubtedly has contributed to the rise in the numbers of uninsured, but we should remember that health insurance premiums were also increasing in the 1950s and 1960s when health insurance coverage expanded. Private health insurance premiums were also quite stable in the early 1990s, even declining in real terms, yet the number of uninsured individuals continued to climb steadily by 1 million people a year. So, over a longer period, there was no systematic relationship between increases in premiums and number of uninsured individuals.

When examining the recent history of different types of coverage, it is clear that the growth of the uninsured from the mid-1970s to the mid-1990s was a result of the erosion of employment-based health insurance coverage. One contributing factor was the restructuring of American industry over this period; manufacturing jobs declined, and service sector jobs expanded, which meant a shift away from firms with good health insurance coverage to those with poor coverage. Employers also took a number of cost-reducing steps: They increased employee premium shares and reduced or eliminated financial support for coverage of spouses and children. In 1998 dollars, the cost of job-based insurance increased 2.6-fold, and the contributions of employees for coverage increased 3.5-fold; this contributed to a decline in the percentage of nonelderly Americans covered by job-based insurance from 71% to 64%.[14] This increased premium cost for workers has led an increasing number of low-wage workers to decline employer coverage, even when it is offered. The rise in the number of uninsured workers over the period 1977 to 1998 was almost entirely among workers with a high school education or less.

Medicaid coverage expanded in the late 1980s and early 1990s, with the legislative changes covering more low-income pregnant women and children. This expansion of Medicaid coverage offset the erosion of employer-based coverage to some extent, but not sufficiently to stem the rise in uninsured (Fig. 3).

The trends since 1993 have been somewhat different. Employer coverage has stabilized as a percentage of the total population and increased somewhat in absolute numbers.[15] However, Medicaid has reversed course and is covering a smaller

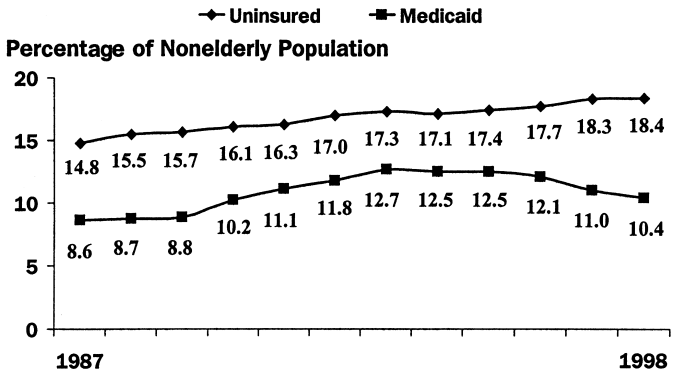


**FIGURE 3.** Growth in uninsured Americans and Medicaid beneficiaries, 1987–1998. (*Source:* Employee Benefits Research Institute estimates of the March 1998–1999 Current Population Survey.)

percentage of the population. Between 1997 and 1998, for example, 1.2 million fewer people were covered by Medicaid. Thus, for the last 5 years, it is mostly the loss of Medicaid coverage that accounts for most of the rise in the uninsured. Some of this may be caused by a better economy, by movement from welfare to work, or by movement from unemployment to work. Unfortunately, record low unemployment and reduced welfare rolls do not appear to be leading to substantially increased job-based coverage. Women leaving welfare may also be unaware of their continued eligibility for Medicaid coverage or of coverage options for their children under Medicaid and CHIP.

A number of myths about the uninsured persist. Shockingly, only 28% of Americans know that more than 40 million are uninsured, and 47% think the number of uninsured persons has stayed the same or decreased over the past 5 years.[16] Of Americans, 57% think the uninsured are able to get the care they need from doctors and hospitals. Despite the wealth of research and data on the uninsured, the true message is still not permeating wide segments of the American public.

Another myth is that the uninsured are young and healthy. It is true that young adults are more likely to be uninsured than other age groups. Of the uninsured, 8 million are between the ages of 18 and 24 years, which represents about 20% of all young adults. However, this is still a small portion of the total of 44 million uninsured. About 11 million are children under the age of 18 years, even though two-thirds of those either are eligible for Medicaid or CHIP or would be eligible if states took full advantage of the option of covering all children in families with incomes below 200% of poverty.

A more recent myth is that the uninsured are well-to-do but simply prefer to go without health insurance coverage. In fact, about 55%—24 million of the 44 million uninsured—have incomes below 200% of the poverty level (Table).

Minority Americans are at much greater risk of being uninsured. Of Hispanics, 37% are uninsured compared with 14% of non-Hispanic whites and 24% of blacks.[17] Even after adjusting for wage rates, working Hispanics and blacks are much more likely to be uninsured.[18]

Working is certainly no guarantee of having adequate health insurance coverage.[19,20] The majority of the uninsured work or are dependents of workers. About 60% are in families in which someone works full time all year, and another 24%

**TABLE. Number of uninsured by age and poverty level, 1998**

| Uninsured, millions | Under 100% of poverty | 100%–199% of poverty | 200%–299% of poverty | 300% of poverty or higher | Total |
|---|---|---|---|---|---|
| Age, years | | | | | |
| Under 18 | 3.7 | 3.6 | 1.8 | 2.0 | 11.1 |
| 18–44 | 6.0 | 7.0 | 4.7 | 6.9 | 24.6 |
| 45–54 | 0.9 | 1.1 | 0.9 | 1.8 | 4.8 |
| 55–64 | 0.7 | 0.8 | 0.6 | 1.3 | 3.4 |
| 65 and over | 0.1 | 0.1 | 0.1 | 0.1 | 0.4 |
| Total | 11.5 | 12.6 | 8.1 | 12.1 | 44.3 |

*Source:* Employee Benefit Research Institute and Columbia University Estimates from the March 1999 Current Population Survey.

are in families with a part-time or part-year worker. Only 16% of the uninsured are in families without a working adult.

In fact, those working part time or who are self-employed are no more likely to be insured than those not currently working. According to the new Commonwealth Fund 1999 National Survey of Workers' Health Insurance, about one-fourth of part-time workers, of those who are self-employed, and of those not currently working are uninsured compared with 15% of full-time workers. Without the contribution of employers to coverage, health insurance is unaffordable for many workers.[21]

But, even among full-time workers, those with lower wages are much less likely to be insured. Of adults working full-time with a family income of $20,000 or less, 42% are uninsured; this figure is 22% for those with incomes between $20,000 and $35,000 and only 4% for those with incomes of $60,000 or more.[22]

In part, this is because low-wage workers are more likely to work in small firms less likely to provide coverage. About one-fourth of adults employed in private firms with fewer than 25 employees are uninsured; this compares with 9% in firms with 500 or more employees. But, even in larger firms, low-wage workers are much less likely to be covered than high-wage workers. This most likely is related to the unaffordability of the employee share of the premium for low-wage workers. Employers not offering coverage or employees not being able to afford premiums are the most common reasons given by the uninsured for not being covered.

## OPTIONS FOR PROVIDING COVERAGE TO THE UNINSURED

Since most of the uninsured cannot afford health insurance coverage, simply requiring them to purchase coverage—sometimes called the *individual mandate*—is not a feasible option. Annual premiums for employer-sponsored insurance average $2,270 for individual coverage and $5,742 for family coverage.[23] Though employees usually share the cost of insurance with their employer, those who do not have the opportunity to participate in employer-sponsored coverage face these, or even higher premiums, on their own. Instead of requiring the uninsured to buy coverage that is beyond their financial means, it is clear coverage will need to be subsidized in some way, either by employers or federal or state government taxpayers. There are four general strategies for providing and financing coverage for the uninsured:

federal tax subsidies, coverage under federal health insurance programs, state health insurance programs, or expanded employer coverage. Each of these options has advantages and disadvantages, including equity of financing burden, degree to which expanded coverage is targeted to the uninsured as opposed to substituting for existing coverage ("efficiency"), administrative ease, and public support. Depending on the specific proposal, a given strategy may have other desirable attributes as well, including adequacy of coverage, quality of care, portability and stability of coverage, choice, and continuity in physician-patient relationships.

### Federal Tax Subsidies

One of the most popular options at present is providing personal income tax subsidies to individuals to purchase coverage. There are a number of ways in which such a proposal can be designed. It could be targeted to low-income households, such as providing a $2,000 tax credit for individuals with low income up to $16,900 (approximately 200% of the federal poverty level) with a complete phase out of the tax credit when income reaches $30,000. Another option would be a smaller tax credit available to all (e.g., $500 per household). More modest proposals would accelerate the deductibility of health insurance premiums for the self-employed or make health insurance premiums not subject to a percentage of adjusted gross income exclusion. Tax credit proposals have been advanced by both Democrats and Republicans in the Congress and would appear to have broad support.

The advantage of a federal tax subsidy is that it is financed progressively. Other advantages include that it promotes choice and lets families pick coverage that best suits their needs. On the downside, coverage purchased through the individual health insurance market is often costly, low quality, and in some states, not guaranteed for individuals with serious health problems.

Tax experts point out that health tax credits add complexity to the tax code, increase the potential for fraud, and run the risk of undercutting honest reporting of income. If taxpayers perceive that others are "gaming" the tax system or getting unfair credits, it undermines general compliance with accurate tax filing. Taking advantage of the tax credit may vary across households, with some being unaware of this benefit.

Further, there is no free lunch; health tax credits need to compete with other uses of federal tax dollars, including other kinds of tax cuts or expenditures for Medicare, Social Security, education, defense, or other federal budget priorities.

Probably the greatest concern is that a federal tax credit would lead to an erosion of employer coverage. An employer of low-wage workers who now provides coverage would see little reason to continue to do so if all low-income individuals received a credit of $2,000 per person credit to purchase their coverage. While a tax credit can be designed easily to target low-income individuals at highest risk of being uninsured, it would be available to both the insured and uninsured and therefore not be well targeted to new coverage.

### Medicare and Federal Employees Health Benefits Plan

Another alternative is to expand coverage through existing federal health insurance programs, either Medicare, which covers 39 million elderly and disabled people, or the Federal Employees Health Benefits Plan (FEHBP), which provides coverage to 9 million federal employees. President Clinton and Vice President Gore have proposed opening up Medicare to individuals between the ages of 62 and 64 and

selected other older adults between the ages of 55 and 64. During the Democratic primary race, Senator Bill Bradley proposed permitting individuals and employers to buy into the FEHBP program with financing through a federal tax credit.

Both programs have low administrative overhead, reasonably good benefits, multiple choices of fee-for-service health insurance and managed-care options, and a relatively stable group of participating insurers. Medicare has developed a sophisticated set of quality standards for participating managed-care plans and is beginning to provide beneficiaries with information on both Medicare beneficiary ratings of plans and clinical quality indicators.

Permitting older adults to buy into Medicare makes sense in that they all will become eligible for Medicare shortly. However, many older adults are not likely to be able to afford an actuarially fair premium without subsidies.

The FEHBP is also an attractive option. Federal offices exist all over the US, as do Medicare offices, that could be used to assist people with enrollment. However, unlike federal employees, whose premium share is deducted from their paycheck, the federal government would need to develop new administrative mechanisms to collect premiums, transfer tax credits from the US Treasury to the FEHBP, handle enrollment and disenrollment, and disseminate information on plans.

The greatest concerns of "voluntary buy-in" to federal programs are that only the sick will apply or the uninsured will wait until they are in need of expensive care to enroll. This could increase the cost to the program, and if the premium for other federal employees were tied to this experience, attraction of "bad risks" could result in spiraling premiums.

If coverage were subsidized— for either low-income or high-risk enrollees— this cost would add to the size of the federal budget and tax revenues required to support it. On the other hand, like federal tax credits, federal income tax financing is the most progressive method of financing. It also has the advantage of permitting cross subsidies from low-income areas of the country to high-income areas.

### State Programs

State-administered health insurance programs also provide a base on which to build. Medicaid covers 35 million low-income Americans with matching federal-state funding. The new state CHIP programs cover over a million children, with a somewhat higher federal-to-state matching of expenditures. In addition, some states, such as Minnesota and Washington, have established health insurance coverage programs that are fully funded by the state.

Most CHIP programs have encountered considerable difficulty reaching and enrolling eligible children. Unlike welfare, for which the state has an ongoing administrative relationship, low-wage working families do not regularly come in contact with state eligibility offices, and some are put off by the program's complexity or image. Focus groups, however, suggest that when parents are informed about the program, they are eager to have their children covered. It is possible that enrollment will grow over time as it has in states like New York that have had their own program since the early 1990s.

One option for expanding coverage through state programs would be to enroll the parents of children covered by Medicaid and CHIP. In this case, the state has established an administrative relationship with the family, so outreach is relatively straightforward. Under the 1996 welfare reform law, states can raise effective income thresholds so they are sufficient to cover all parents of children covered by

Medicaid. New legislation would be required to cover all parents of CHIP-eligible children.

Another option would be for states to permit individuals and small businesses to buy into state public employee insurance plans, similar to the proposal to permit purchase through the FEHBP. Or, states could use the fact they purchase coverage (in some cases, for almost one-fourth of the state's population) through Medicaid, CHIP, state public employee, or state-only programs to require participating plans to make coverage available to small businesses and individuals at an affordable rate.

The advantages of these state options for expanding health insurance coverage are that they build on existing administrative mechanisms and permit flexibility to fit varying geographic and population characteristics and circumstances. Some states have named their CHIP and Medicaid programs catchy names such as BadgerCare, Dr. Dinosaur, or PeachCare to appeal to local residents.

The disadvantage of building on existing programs is that, to date, outreach and enrollment efforts for CHIP have fallen short. There are no ideal administrative mechanisms for collecting premiums and cost-sharing from low-income families, and as with federal program expansion, state programs may contribute to the decline of employer coverage for low-wage workers and their dependents.

### Employer Options

Since intense opposition from small businesses to mandated employer coverage helped defeat the Clinton Health Security Act, little consideration has been given to asking the employer community to bear a share of the cost of coverage for the uninsured. Yet, there are strong reasons for doing so. In fact, most of the major health insurance proposals advanced over the last 30 years have had a role for employer contribution, including the Nixon employer mandate, the Carter minimum standards on benefits and employer premium share, the Pepper Commission's pay-or-play plan, and the Clinton plan.

Put simply, it is hard to afford coverage for the uninsured strictly through new personal income taxes, and it is hard to target coverage to just the uninsured if workers who earn similar incomes but are insured by their employers do not benefit as well. Without a requirement that employers contribute toward coverage, there is a risk that some employers would drop coverage in the face of new programs for which their workers would qualify.

There are different ways by which employer coverage could be expanded. Tax subsidies could be provided to small, low-wage businesses as an incentive to provide coverage. Or, the cost of the low-wage worker's share of premiums could be offset through tax credits paid through employers. Both, however, would seem to imply that employers also make a contribution.

Advantages of employer-based expansion options are that they build on the current system that covers 155 million Americans, could be targeted on low-wage workers most at risk, have the least likelihood of "crowding out" employer coverage, and minimize the need for government regulation or administration.

Disadvantages include that they may not work well for the contingent workforce, such as the self-employed, independent contractors, temporary and part-time workers, or employees of small businesses—all of whom are a significant and growing part of a 21st century workforce. Such options may need to be coupled with health insurance market reform to improve the affordability and accessibility of

coverage for small businesses. Alternative mechanisms may include permitting small businesses and contingent workers to buy into existing health insurance systems with a large enrolled population and provision of negotiated contracts with an array of health insurance and managed-care plans, such as those offered by federal or state programs. Finally, any option that increases costs to employers runs the possibility of leading to a reduction in employment.

There is also strong support for having government help low-income workers and their families afford health insurance by helping workers pay for insurance offered by their employer; this is favored by 85% of Americans.[24] Somewhat fewer Americans, although still a large majority, would favor helping low-income workers and their families obtain health insurance by setting up new government programs for workers (79%) or by expanding existing government programs to offer free coverage (67%).

Having employers contribute $0.75 an hour toward coverage for minimum-wage workers is also supported by 65% of Americans, more than those who favor financing expanded coverage by requiring health insurance companies to pay additional taxes (58%), raising payroll taxes paid by employers (39%), or raising income taxes (21%).

## CONCLUSION

The 2000 presidential election has brought the issue of expanding health insurance coverage back into the spotlight. Voters do agree that passing laws to help uninsured Americans obtain health insurance is a top priority. This view is held both by those voting Democratic (73%) and by almost half of those voting Republican (48%).[25] Public concern is also reflected in the increasing attention in the news to the plight of the uninsured.

Good economic conditions bode well for renewed attention to the issue. The federal budget is in surplus, as are many state budgets. Medicare's budgetary problems are less acute, given the 1997 Balanced Budget Act and improved economic and Medicare forecasts. Part A of Medicare is now projected to be solvent through 2015. The enactment of incremental health insurance such as the CHIP program proves that legislative change is possible with bipartisan support, and it provides one possible base on which to build.

A new century should also lead to a renewal of optimism and a sense of new possibilities. The United States enters this new century with a strong economy, rising real incomes, and the first federal budget surplus in two decades. Peace and prosperity—the absence of which often worked against change in the past—may contain the ingredients for renewed attention to universal health insurance coverage. A tight labor market (a consequence of lower birth rates beginning in the late 1960s), concern among working families about health and economic security in the event of major illness and the ability to obtain needed health care, and the discrimination against those at high health risk endemic to private health insurance coverage all contain the seeds for change.

With such economic prosperity, ensuring that all Americans share broadly in it and have access to health care necessary to be healthy and productive and ensuring that their children get off to a healthy start in life are both achievable and worthy goals of a new century. We cannot continue with a health system that excludes some of our people because they lack health insurance or because of their race, ethnicity, or income.

By mobilizing visionary health care leaders, dedicated health professionals, and a concerned public, we can improve the performance of the US health system and, in the 21st century, join the world community of nations that ensure universal access to health care for all their people.

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