

Health Benefits: Comparing the U. S. System with Universal Systems

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Abstract: The U. S. remains the only industrialized nation that lacks a universal health care system. As a result, at least 45 million citizens lack health insurance coverage. It is argued, however, that the various health benefits and entitlements available to U. S. citizens actually form a universal health care system, albeit in a piecemeal fashion. This paper will explore the policy differences between universal national health care systems and the piecemeal system that exists in the U. S, and will further explore characteristics of health care systems that make them more and less effective. The paper concludes with recommendations for improving access to health care in the U. S. by developing a universal health care system that reflects those characteristics proven most effective in other universal systems.

Introduction

The U. S. remains the only industrialized nation that lacks a national health care system. As a result, at least 49 million citizens lack health insurance coverage of any kind (United States Census Bureau, 2003). It is argued, however, that the various health benefits provided through such mechanisms as Medicare, Medicaid, SCHIPS, Workers' Compensation, Veterans' Benefits

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and Victim Compensation actually form a universal health care system, albeit in a piecemeal fashion. This paper will explore the veracity of the assumption that health care in the U. S. is universal in any fashion. It will then explore the policy differences between the universal health care systems of other industrial nations and the piecemeal system that exists in the U. S, and will further explore characteristics of health care systems that make them more and less effective, regardless of the type of system that they reflect, ending with recommendations for improving access to health care in the U. S.

Health Care System Design: Universal vs. Market-Based

A universal health care system is one that guarantees essentially similar health care coverage to all of its citizens. It not only pays for health care, but ensures that adequate health care facilities and providers are available where they are needed. Universal systems differ significantly from each other, however, with the result that some health care systems are more or less adequate even though they may share the characteristic of “universality” (Himmelstein & Woolhandler, 1994).

Despite their differences, all universal health care systems reflect clear advantages regarding breadth of support, continuity and reliability of coverage. Breadth of support, reflecting the extent and diversity of citizens who benefit from the system, derives from the fact that a single system covers the entire population, and is consequently favored by most of that population. Continuity, or the ease with which covered individuals retain the same benefits if they change jobs, relocate or retire, assures recipients of coverage from “cradle to grave.” Even though there may be some changes in the source of coverage, recipients are assured of similar

services at similar rates, often offered by the same providers. Reliability, derived from both support and continuity, suggests that recipients can reasonably expect similar coverage throughout their lives. Universal systems also focus on preventive care, or health maintenance, which is less costly than treatment for illnesses and injuries; and prioritize less costly treatment methods when treatment is indicated (Himmelstein & Woolhandler, 1994).

The U. S. “system,” on the other hand, is an amalgam of private fee-for-service, entitlement and benefit programs. Private fee-for-service programs pay providers for services rendered (Karger & Stoesz, 1998). They are widely diverse, depending on cost, the availability and cost of health care in different regions of the country, the size and health of the group covered, and the amount of coverage cost assumed by a third party, such as an employer. However, as all are market-based, they are all far most costly than universal models offering similar services (Woolhandler and Himmelstein, 1991).

For the purposes of this paper, entitlement programs, “services, goods or money due to an individual by virtue of a specific status” (Ginsberg, 1999, p. 148), are limited to those government programs that are contributory in nature, and that, therefore, give recipients a sense of entitlement to them. Even so, entitlements tend to be less generous than private insurance programs. Entitlement programs such as Workers’ Compensation depend upon contributions to the system by future recipients, which may fall short of the needs of current recipients. Other entitlement programs, such as Veterans’ Benefits, depend on tax dollars, for which they must compete with all other tax-funded programs for resources. Still other entitlement programs, such as Social Security, are funded by a combination of tax dollars and recipient contributions, making them subject to both competition for dollars and shortfalls when expenditures outpace

revenues. Some entitlement programs also limit coverage to specific types of illnesses or injuries. For example, Workers' Compensation covers only illnesses or injuries that occur during the course of employment. Therefore, a person forced to retire following a Workers' Compensation injury will be covered for related health needs, but not for health problems unrelated to the covered illness or injury (Goldberg, 1991).

As limited as entitlement programs are, they are not as limited as non-contributory benefit programs, which tend to be residual in nature. Residual programs are programs designed as a temporary response to individual or systemic failures (Gilbert & Terrell, 1998). Programs such as Medicaid are designed to provide meager benefits to those who cannot afford fee-for-service healthcare, are not covered by an employer and fail to qualify for entitlements. By definition, residual programs are designed to be inferior to their alternatives, as a means of ensuring that people who can afford, or are eligible for, alternatives will not use their residual counterparts.

Any universal health care system will be more cost-effective than a piecemeal one because universality eliminates the need to connect illnesses and injuries to discrete causes, requires less complex proof of eligibility and greatly reduces the costs of maintaining multiple administrative and legal systems. Ironically, this is particularly the case when a piecemeal system like that of the U. S. offers many disparate types of health care benefits for discrete types of illness and injuries, sometimes based not on the type of injury but how or where it was sustained. This, in turn, results in further costs, as delays in determining coverage delay treatment (Woolhandler and Himmelstein, 1991). At best, delaying treatment postpones

amelioration of symptoms. At worst, it results in poorer prognoses than would have occurred had treatment been provided earlier, thereby exacerbating illness or injury.

U. S.-style provision of health care privileges those who are, or have been, tied to the upper levels of the employment sector. Only those employers who must compete for highly skilled professionals need to lure them with generous health care programs. Ironically, although unions opposed universal health care systems because they believed that they could more effectively advocate for better health care for members, union membership has decreased with the demise of “rust belt” industries, and manufacturing jobs are increasingly being outsourced overseas (Goldberg, 2002). Today, employers prefer to hire part-time, short-term or contract workers, who are ineligible for most fringe benefits, for lower-level work.

For the rest of the population, U. S. health care covers a limited range of involuntary risks (Clarke & Piven, 2001), attributing the cause of injury, and the cost, in a way that places fault for its occurrence in order to assign payment responsibility. Piecemeal programs also vie for funding against programs or services for other defined groups, and because such funding is subject to the political process, the best supported services are generally funded, whether or not they reflect the areas of greatest need (Himmelstein & Woolhandler, 1994). For example, since September 11, 2001, all other government programs have had to compete for funding with the wars in Afghanistan and Iraq and the domestic effort to prevent terrorism. In addition, because each piecemeal program only covers a small portion of the population for narrowly defined injuries and illnesses, lawmakers and the public assume (usually erroneously) that the people counting on the lost benefit will be able to find an alternate program to meet their needs.

Market-based U. S. insurance proffers greater choice than is generally available in universal health care systems. As few patients are qualified to self-diagnose and self-treat, however, the selection criteria used by patients is likely based upon factors unrelated to effectiveness. Failure to limit treatments to the most effective methods can increase costs without improving health. As a result, U. S citizens with generous insurance coverage are not necessarily provided better care. Instead, they are often offered more costly, invasive treatments, when simpler, cheaper methods would be as effective for their conditions; or are encouraged to submit to experimental procedures that may be unlikely to affect their conditions (Himmelstein & Woolhandler, 1994).

Piecemeal health care ignores needy recipients because they are assumed to be eligible for other of the “myriad” public health care benefits available. It also omits some recipients through complex application procedures and arcane eligibility rules, which potential recipients are rarely familiar with until they have need of the benefit. Often recipients do not even know of the existence of a benefit until after they have sought help to pay medical expenses (Levinson, 1988). People who have low reading levels, do not speak English as a first language, are unfamiliar with bureaucracies or are too ill or traumatized by their health problems may be unable to comply with the application rules (Bendick, 1980, Bendick & Cantu, 1978).

Relocation, job change, divorce or retirement can also affect health care eligibility. As a result, even some people who are insured have conditions that preexisted their insurance coverage, and that are therefore not covered, while other people remain in jobs, marriages or locations where they are unhappy rather than lose their insurance coverage.

Furthermore, the high cost of insurance deters younger people, who tend to be healthier, from purchasing insurance, although lack of preventive care at their age may contribute to greater health care costs for them later, when they are covered by employer-based health insurance or are Medicare-eligible (Himmelstein & Woolhandler, 1994). Reliance on the market also leads providers and facilities to glut areas where the population is well-insured, and ignore those where people desperately need health care but are too poor to pay for it (Himmelstein &

Woolhandler, 1994). Therefore, even well-insured people may have difficulty accessing health care if they live in parts of the country that are rural, or where most of the population is not well-insured. The barriers, fragmentation and other inadequacies of access prompted one expert to describe our society as “overserviced but underserved” (Levinson, 1988), suggesting that the problem of insufficient health care is exacerbated by the very range of services that exist, which obfuscate the inadequacy of each.

The Historical Development of Health Care Systems

Much of the problem relates back to the rationales by which health coverage is provided. Universal coverage assumes that all people face health problems during their lives, and that the most effective and fair way to pay for those costs is to share them broadly. This idea carries over to the smaller number of people with extremely high health care costs, who are often unable to work and would be unlikely to be able to afford to pay for their own health care.

Most nations adopted universal health care after a war or natural disaster that affected most of the population, and helped the country to recognize the universality of the need for health care. The U. S. has little experience with national disaster, and immigration and migration have made citizens perceive the population as made up of people with very different priorities, spending and health habits. This “otherness” may have contributed historically to citizens’ unwillingness to cover the health care needs of its fellow citizens.

Social policy experts also attribute the lack of national health care to the fact that it was not until the Depression of the 1930s that U. S. policy makers faced the fact that in the “land of plenty” there was need for a “safety net” (Leiby, 1978). However, Skocpol (1992) argued cogently that opposition to social insurance was not predicated on beliefs in “rugged individualism” alone, but also on fears of corruption, which has historically accompanied non-contributory benefits in this country. Skocpol pointed out that, for instance, before Germany and Great Britain had developed their social insurance programs, they had professionalized and depoliticized their civil service systems, assuring that their programs would be run fairly and efficiently. The only prior experience that the U. S. Had had with federal social aid programs up to that point had been with Civil War pensions, which had been fraught with corruption; and there was no reason to believe that the government’s patronage-appointed staff was capable of administering a new program any differently. Supreme Court Justice Louis Brandeis (1927) opined, “our government does not now grapple successfully with the duties which it has assumed, and should not extend its operations at least until it does.” Rather than grapple more successfully with its duties, however, U. S. policy makers chose to develop benefits that were contributory in nature, in the hope that politicians would be more cautious in awarding funds when contributors themselves could monitor their allocation.

Even so, it took an explosion of litigation for the government to develop its next large-scale benefits program, Workers’ Compensation. This followed a period during which courts and legislatures expanded workers’ abilities to collect damages against employers for industrial injuries. Workers’ Compensation was seen as a way for employers to control and plan for these costs more rationally (Skocpol, 1992).

Ironically, one “selling point” for workers’ compensation programs was that they were to be overseen by non-partisan commissions which would facilitate settlement of claims, develop and clarify eligibility rules, coordinate efforts with other labor and regulatory agencies and

conduct studies on industrial conditions. Seminal to this concept was the idea that these commissions would not only assess damages against employers based on the number and severity of injuries sustained in their workplaces, but would use the information gained in this work to develop guideline to increasingly prevent workplace injuries. However, workers' compensation commissions rarely developed this latter aspect of their charge fully. In fact, some became as corrupt as had Civil War pension commissions (Skocpol, 1992).

When the Depression left the United States with no choice but to provide government-sponsored benefits, they were non-contributory only during their initial, emergency phase, soon to be replaced with contributory Social Security benefits. Any chance for universal health care was squelched by fears of policies that suggested a hint of "socialism." Additional benefits were not added, nor benefits expanded significantly, until the 1950s, when non-contributory benefits were targeted to the poor, who simply could not afford to contribute to benefits (Tice & Perkins, 2002). Further, the timing of these benefits suggest that they were not only meant to offset poverty, but to quell civil unrest, as Frances Fox Piven and Richard Cloward (1971) demonstrated in their classic book, *Regulating the Poor*. However, during the remainder of the 20th Century, inflation and then service cutbacks eroded the benefit levels until many programs were barely able to meet the most basic of needs (Rosen, et al., 1987).

From the beginning of the post-WWII period, in part as a result of the creation of health benefits such as Medicare and Medicaid, and in part as a result of more research and higher living standards, public expectations of health care changed. It was no longer considered "natural" for large numbers of children to die each year from influenza, scarlet fever or tuberculosis. This prompted some to again advocate for universal health care; but it led others to invest public resources only in addressing communicable diseases to prevent mass contagion, maintaining the residual nature of publicly subsidized health care. The lack of alternative medical care had the effect of trapping many single parents in Aid to Families with Dependent Children (AFDC), because Medicaid eligibility was tied to AFDC participation (Gordon 1998). Of course, this became a moot point when the Clinton Administration ended "welfare as we knew it" (Trattner, 1999), eliminating AFDC and creating TANF with tight time limits.

From 1970 to 1990 the average size of a U.S. household decreased 21%. This change was not equally distributed: more people never married while more couples remained childless—but poor families tended to have higher number of children. As a result, in 1990, 80% of U. S. children were supported by 30% of the U. S. population, and many of those in the 30% were poor families (Tice & Perkins, 2002). Furthermore, cuts in nutrition programs and to housing and home heating assistance that occurred over the same time took a further toll on poor populations, increasing their need for health care to undo damage caused by unhealthy environments.

U. S Health Care Today

The U. S. system has expanded coverage to some population groups, including children and seniors. For example, Table 1 shows that the State Child Health Insurance Program (SCHIP) had enrolled 4.6 million children by 2001 (Center for Medicaid and State Operation, 2001b). However, 63.9% of children continue to receive health insurance through their parents' employers, while another 23% relied on Medicaid—and 11.7% of U. S. children remained uninsured (Center for Medicaid and State Operation, 2001a), as seen in Table 2. It should also

come as no surprise that uninsured children in the U. S, like their adult counterparts, are disproportionately likely to be poor and/or to belong to a minority group (DeNavas-Walt, Proctor & Mills,2004).

Table 3 depicts the fact that most Medicare beneficiaries with drug benefits pay out-of-pocket costs for prescriptions, but those without such coverage pay nearly twice as much out-of-pocket for prescriptions (Center for Medicare Statistics, 1999b). Medicare recipients also pay an average of \$1825 each for co-payments and non-covered health services, (Center for Medicare Statistics, 1999a), as shown in Table 4. However, uninsured adults under 65 face the most significant barriers to health care. Table 5 shows that they frequently postpone or forego needed care, fail to fill prescriptions and have medical bills impact on their lives significantly (Kaiser Family Foundation, 2000).

Increasingly, too, as Table 6 demonstrates, people with higher incomes are among the uninsured (Actuarial Research Corporation, 2000c). By 2000, nearly half of the uninsured had incomes exceeding 200% of the poverty line (Actuarial Research Corporation, 2000b), as seen in Table 7. Table 8 shows that this trend continues even for people with incomes four times the poverty level (Actuarial Research Corporation, 2000). Despite the health care they forego, the uninsured pay 250% more for health care than the insured, (Actuarial Research Corporation, 2000a), as depicted in Table 9, not only because they lack coverage, but because insurance plans negotiate lower rates for groups (Himmelstein & Woolhandler, 1994). Further, 50 million people who have insurance risk bankruptcy in the event of a major illness due to inadequate coverage (Himmelstein & Woolhandler, 1994). Although laws, economies and employment availability vary by state, affecting the proportion of residents who are uninsured, as depicted in Table 10, it is clear that no state has an adequately insured population (United States Census Bureau, 2000).

Even if the U. S. had the best health care, the fact that it is unavailable to at least 45 million people makes it woefully inadequate. However, the facts prove U. S. health care's inadequacy: infant mortality and life expectancy rates are lower than those of most industrialized countries, and further, they are even lower for poor and minority populations within the U.S. (Centers for Disease Control and Prevention, 2002; DeNavas-Walt, Proctor & Mills,2004). It is clear that U. S. Health care is inadequate by any measure.

Characteristics of Universal Systems

Traditionally, the German system developed by the Bismarck government was considered a model of universal health care. Not only was it the first such system, but until recently it offered a generous program of benefits run with efficiency and competence by a professional, apolitical civil service (Skocpol, 1992). However, Germany has begun to reshape and, in some aspects, dismantle this program, incorporating more out-of-pocket costs and co-payments (Bäcker & Klammer, 2002). This began in the 1980s, shortly after reunification, suggesting that in addition to the increases in health care costs affecting all systems, and the greater cost of incorporating new citizens, former West Germans were not as willing to extend their generous benefits to former East Germans, whose renewed citizenship affected the German economy profoundly.

Today, the Scandinavian countries exemplify the best example of effective universal health care, with Sweden's being, if not the best of them, at least the most-studied, (Alcock,

2001). Sweden's health care system is also the most universal, in that it is completely free to users and is funded entirely by the Swedish national government (Alcock & Craig, 2001). Other universal systems spread their funding responsibility; for instance, the cost of Germany's system is shared by employers, claimants and various levels of government (Alcock & Craig, 2001). But not all universal health care systems are as effective: Italy's system suffers from the distrust of government that pervades Italian society (Fargion, 2001), while France's system has experienced steadily escalating costs due to illogical design and decentralized operation, and has added co-payments as a result (Kesselman, 2002).

The British systems have been alternately lauded and derided. Although the British system was originally quite generous, Thatcher Era cuts crippled it with long waits and serious service cutbacks (Alcock and Craig, 2001). The Canadian system differs somewhat from that of the United Kingdom. Its federal government supports hospitals and insurance coverage, but cedes responsibility for health care to the provinces (Lightman and Riches, 2001). As a result, services can differ significantly from province to province. The Canadian system has also retrenched in recent years, following the Thatcher Era model (Evans, 2002). New Zealand also followed the British path toward universal health care, with subsidized doctors and prescriptions, free hospitals and laboratory and diagnostic services. However, Davey (2001) notes that aboriginal New Zealanders consistently receive inferior health services from the system, undermining its true universality.

Eastern European health care is reeling following the end of the Soviet Union, but Eastern Europeans are clearly unwilling to forego "socialized" medicine, regardless of the political path they follow. Although striving to maintain universal health care, Eastern European countries are hamstrung not only by the escalating costs caused by increased technology, longer life spans and decreased infant mortality, but by poor economies contrasting with high citizen expectations. Russia, for example, currently spends little on health care, but has a wealth of practitioners trained under the Soviet system (Manning & Davidova, 2001). Hungary, on the other hand, has restructured, but now provides superior services for those with earned incomes (Baxandall, 2002). Furthermore, lack of provision for long term care has led to bribery by families seeking to keep elderly relatives in the hospital. Expectations of gratuities, which have always been part of the Eastern European system, have increased in Hungary (Baxandall, 2002) and throughout Eastern Europe (Vinogradov, 2004).

Farther east, Japan offers seven separate systems based on employment groups, with mandatory health insurance and separate subsidies based on employment groups (Nomura and Kimoto, 2002). The Japanese "corporate-universal" system also assumes that family members will provide the bulk of care for ill or elderly family members, but social trends, especially women entering the work force, are making this increasingly difficult (Uzuhashi, 2001).

Hong Kong falls somewhere between the British and Eastern models, as it struggles to both easternize and update its health care system. Hong Kong funds clinics, but not private consultations with physicians. It similarly operates a hospital authority but not a more universal health authority. Waits and overcrowding result. However, Hong Kong enjoys extremely low infant mortality rate and high life expectancy (Wilding & Mok, 2001). This serves as a reminder that results are what matter when assessing policy, although health results derive from many factors, including diet, exercise and stress levels, and should not be the only method used to assess health care.

Clearly, there are many models of universal health care systems, some far more effective than others. National budgets and priorities, citizen expectations and advancing technologies require constant reevaluation and restructuring to enable health care systems to meet current recipient needs and adapt to changes in any of the factors affecting operation. However, the overriding advantage of universal health care in these times is that there is only one health care system to change.

Current Imperative

Both universal and market-based health care systems are struggling to adapt and improve in the face of but costly, new medical technology, increased public expectations of health care for a range of injuries and illnesses as well as more controversial services, such as substance abuse treatment and grief counseling, and people who live longer, but often with special health care, dietary and service needs. However, in the U. S. System, costs are not only escalating, but being borne by a smaller pool of workers due to the imbalance caused by declining birth rates and growing proportions of older people in the population. Yet U.S. policy continues to reflect free market ideology; insisting, despite the contradictory facts, that the market system will produce the best services, at the best prices, in the best locations. Not only has this ideology been disproved by the facts that our health care is so unaffordable, and often inaccessible, it has also been disproved by our comparatively poor infant mortality and life expectancy rates.

It is vital that the U. S. adopt a universal health care model, because the only health care cost that can be cut without losing effectiveness is the wasteful, redundant administrative bureaucracies that result from piecemeal programs. Medical benefits predicated on causes of injury and providing only coverage specific to that cause leave huge coverage gaps, particularly for costs unrelated to the cause of the initial illness or injury.

It is also becoming increasingly difficult to connect injuries and illnesses to specific causes. Coal miners who developed black lung disease and soldiers wounded in battle have no difficulty demonstrating the connection between their medical problems and employment-related causes. Workers who develop carpal tunnel system, however, generally accumulate injuries after a variety of work-related and personal activities. As workers today tend to work for multiple employers, sequentially or at the same time, it is important for the costs of providing medical coverage to be more broadly shared.

This may be an opportune time to adopt universal health care for another reason. The effects of September 11, 2001 have been felt across the nation, with many citizens wondering which part of the country will be the next terror target. This is just the type of national crisis that helped to spawn universal health care in other countries.

Further, the wars in Iraq and Afghanistan are producing large numbers of injured people who would have likely died in previous eras. Improved health care technology has kept more of them alive, but not without long-term if not permanent health care needs. The majority of injured are not soldiers eligible for veteran's benefits, but contract workers dependent on their employers for health coverage. And by now U. S. citizens should recognize the tenuous nature of employer-based health care.

A universal health care system will respond to most of these problems, and is a necessary step in ensuring that the U. S. can have access to affordable, available health care. A universal system would at least offer continuity, reliability and breadth of support, and would prioritize prevention to keep costs manageable.

Although universal health care offers many advantages, aspects of system operation affect how well it works and how fully it satisfies recipients. Aspects of effectiveness are not as clearly tied to the type of health care system, but instead to operational factors, as Table 11 illustrates. As a result, strict cost-containment mechanisms, such as age cut-offs for certain types of procedures, limits on types or amounts of treatment and long wait lists undermine any health care system. Therefore, as this paper has suggested, the U. S. requires not only a universal health care system but one that incorporates characteristics to ensure that it:

- 1.) Is not corrupted by economic or political interests;
- 2.) Does not vary considerably across states or other jurisdictions;
- 3.) Provides coverage for all manner of illness or injury regardless of cause;
- 4.) Has a simple administrative process for enrollment, and pays providers directly;
- 5.) Provides funding to ensure a sufficient pool of practitioners and all types of health care facilities.

The advantage to being the last industrialized nation to create a universal health care system is that there area wide range of models to learn from, and identified mistakes to avoid. The U. S. has waited long enough, and can no longer afford not to have an effective, universal health care system.

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