CHAPTER 7

Health

Life expectancy gap grows as coverage declines

by Elise Gould

Much of this book has focused on wages, income, and wealth across the population. This chapter turns to an examination of another important measure of workers' living standards—health care, particularly employer-provided health insurance, life expectancy, and health care costs.

Vast improvements have been made in health insurance coverage and health status over the last half century. Living standards are better in general, and Americans have the advantage of a more-extensive and far-reaching health care system than ever before. These improvements, though true on average, do not reflect the inequality in the U.S. health care system. While Americans, on average, are healthier and living longer, many are left without adequate insurance coverage or access to the great advances of our health care system. Nowhere are these disparities clearer than in life expectancies, where the gap between the socioeconomically best- and worst-off grew from 2.8 years in 1980 to 4.5 years in 2000.

This chapter begins with recent trends in employer-provided health insurance for the non-elderly population—by various individual and family characteristics. Since the previous business-cycle peak in 2000, fewer people receive this valuable benefit (down 5.4 percentage points), particularly among the less educated and lower income. Children experienced the greatest declines in employer-provided coverage (down 6.2 percentage points), although they have the greatest access to the public health insurance safety net that has kept many of them from becoming uninsured.

The data in this chapter suggest growing disparities in access to insurance, health security, and health outcomes by income, race, and education. Previous chapters have demonstrated the great divide between those at the top of the income distribution and those in the middle and the bottom. Here we reveal how those inequalities play out in the health care landscape. While average life span in the United States has grown, much

of the increase is due to large gains at the top; gains at the bottom have been minimal. Disparities also remain by race: the infant mortality rate of blacks is 2.3 times higher than whites.

One area that affects everyone in the United States is rising health costs. The costs to employers and workers of purchasing coverage and the costs of purchasing health care services are growing much faster than overall inflation and wages. Premiums increased 115% from 1999 to 2007, as compared to increases of 29% and 24% in workers' earnings and wages, respectively. Rising expenses incur an increasing burden on working families, even for those lucky enough to have insurance through an employer.

This chapter concludes with a comparison of the United States with several Organization for Economic Cooperation and Development (OECD) countries in health spending, infant mortality, and life expectancy. While spending on health care in the United States exceeds that of other advanced economies, there is little benefit to show for these higher expenditures in terms of better health outcomes.

Employer-provided health insurance among non-elderly Americans

Chapter 3 (on wages) discussed the rate of employer-provided health insurance for strongly attached workers who get insurance from their own job. This chapter broadens the discussion of employment-based insurance to encompass all types of workers and their dependents. Employment-based coverage remains the predominant form of insurance for Americans under 65, particularly those with ties to the formal labor market. Because the vast majority of those 65 and older have access to Medicare, this chapter focuses on the non-elderly. Not surprisingly, the results here mirror those found earlier in the book.

About 2.7 million fewer people under the age of 65—including workers, their spouses, and their children—had health insurance provided by an employer in 2007 than in 2000. The percent of the non-elderly population with employer-provided health insurance fell from 68.3% in 2000 to 62.9% in 2007, a decline of 5.4 percentage points, despite a productivity-rich and highly profitable recovery (**Table 7.1**).

Although these declines in coverage occurred for all groups regardless of age, sex, race, nativity, education, or household income level, some experienced bigger declines than others. Those with only a high school education and those in the second-to-lowest household income quintile continue to be the hardest hit since 2000. High school graduates were not only less likely than college graduates to have employer-provided insurance (56.4% vs. 80.0%), but they experienced declines in coverage twice as large (9.2 vs. 3.6 percentage-point drops).

Health insurance coverage rates are also dramatically different by age, race, and ethnicity. Since 2000, children under 18 (-6.5 percentage points), adults 18-24 years old (-5.1), and adults 25-54 years old (-6.1) experienced significant declines in employer-provided health coverage. The smaller losses in employer-provided coverage for older Americans may be attributed to the rising employment among this group since 2000.

TABLE 7.1 Employer-provided health insurance, population under 65 years old, 2000-07

	Health insurance coverage (%)		Percentage-point change
	2000	*2007*	*2000-07*
Under 65 population	68.3%	62.9%	-5.4
Age			
0-17 years	65.9%	59.5%	-6.5
18-24 years	53.5	48.4	-5.1
25-54 years	72.9	66.8	-6.1
55-64 years	68.1	67.8	-0.3
Gender			
Male	68.2%	62.5%	-5.7
Female	68.3	63.2	-5.1
Race			
White, non-Hisp.	75.6%	70.8%	-4.6
Black	56.1	51.6	-4.5
Hispanic	45.8	41.4	-4.4
Other	64.3	61.7	-2.6
Nativity			
Native	70.4%	65.1%	-5.3
Foreign born	52.2	47.4	-4.8
Education*			
Less than H.S.	39.0%	30.1%	-8.9
High school	65.6	56.4	-9.2
Some college	73.3	67.0	-6.3
College	83.5	80.0	-3.6
Post-college	87.6	85.8	-1.9
Household income fifth			
Lowest	28.7%	21.9%	-6.8
Second	61.7	53.6	-8.1
Middle	77.4	71.6	-5.7
Fourth	85.6	81.9	-3.7
Highest	88.4	86.4	-1.9

* Education reflects own education for individuals 18 and over and reflects family head's education for children under 18.

Source: Authors' analysis of BLS (2008c) data.

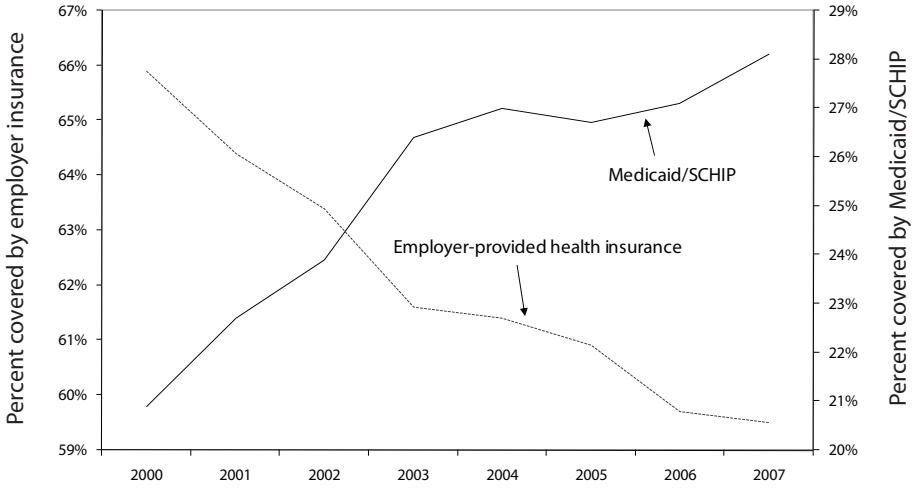
In 2007, 70.8% of whites had employer-provided coverage as compared to 51.6% of blacks and 41.4% of Hispanics. However, each of these groups experienced declines in coverage in excess of 4 percentage points. Being born outside the United States also has a significant impact on the likelihood of having employer-provided health insurance: 65.1% of native-born residents had coverage in 2007 as compared to 47.4% of those foreign born. However, the decline in coverage was pervasive across both groups. A growing immigrant population has not been a major driving force in the fall in overall coverage, particularly since there was a *larger* fall in employer-provided coverage among the native born (5.3 vs. 4.8 percentage-point drop).

Employer-provided coverage fell for all groups across the income scale, and households with the lowest incomes had the lowest coverage rates. Only about one in five individuals in the bottom fifth of the household income scale had employer-provided health insurance, whereas more than four in five individuals in the highest income fifth had coverage. Individuals in households in the second fifth saw the largest declines in coverage, falling 8.1 percentage points, from 61.7% in 2000 to 53.6% in 2007, or nearly 3.9 million fewer Americans with employer-provided coverage in that income group alone.

Children experience lower access to private health coverage

Insurance plays an invaluable role in providing children access to health care. When children lack coverage they experience the burden of health services delayed, including

FIGURE 7A Employment-based health insurance and Medicaid/SCHIP for children under 18 in the United States, 2000-07



Source: Authors' analysis BLS (2008c) data.

untreated illnesses, higher incidence of health problems, higher avoidable hospitalizations, and future financial risks placed on the family. In the short run, poor health undermines a child's achievement in school (e.g., untreated vision, hearing, and oral health problems can all cause distractions from learning). In the long run, better health improves future prospects and increases earnings, which benefits both the future adults and their communities in the form of a better economy and higher government revenues.

Traditionally, workers and their families rely on employer-provided health insurance. By 2007, only 59.5% of children under 18 had such coverage, down 6.5 percentage points from 65.9% in 2000 (see Table 7.1).

As children lost employment-based coverage in the 2000s, they experienced overall gains in public coverage, a trend seen throughout the country. **Figure 7A** demonstrates that, over the last six years, the percent of children covered by the employment-based system has declined, and the percent of children covered by the public system has increased, which presumably has helped to keep more children from becoming uninsured. The share of children receiving Medicaid/State Children's Health Insurance Program (SCHIP) has leveled off since 2004, contributing to a rise in the number of uninsured children for two years in a row.

These results do not identify whether individual children switched from private to public coverage. In fact, some children may lose employer-provided coverage and simply become uninsured, while others move from being uninsured to gaining public coverage. Recent increases in public coverage (excepting the slight decline in 2005) have been the only factor mitigating the continued decline in the percent of uninsured children over the past few years (when employment-based coverage has been leaving more kids uncovered).

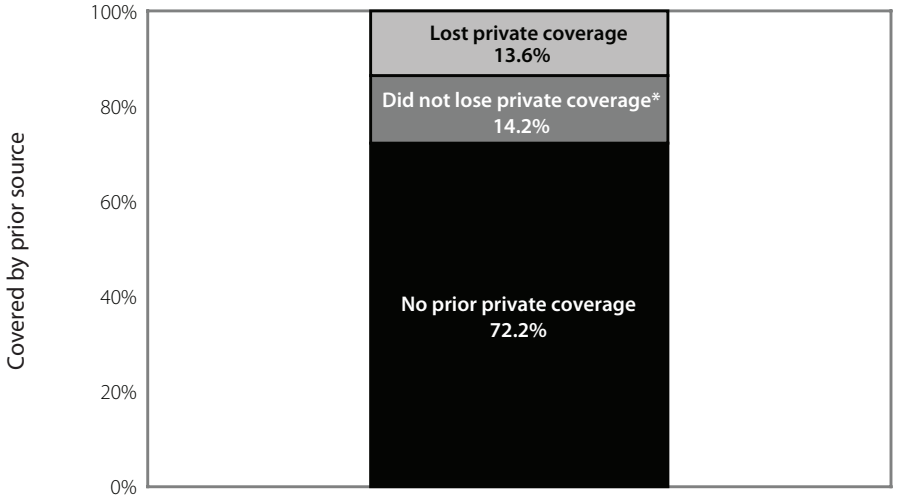
Critics of public health insurance argue that some people will simply drop their private insurance and opt for public coverage. These results, however, *do not* indicate that public coverage is causing employment-based insurance to decline. In fact, both trends are signs of the 2000s slack labor market. In the recent economy, fewer employers offer affordable coverage and more kids fall into the eligible range for public insurance. **Figure 7B** provides direct evidence that public insurance is not simply replacing private coverage. Most SCHIP enrollees (72.2%) were not covered by private coverage six months before enrollment in the public program. Another 13.6% lost coverage within a six-month period prior to SCHIP enrollment due to a lost job, an employer dropping coverage, or a change in family structure (as in divorce, separation, or death of a covered spouse).

This leaves only 14.2% of SCHIP cases that went directly from private to public coverage. More than half of these cases (7.7%) cited an inability to afford private coverage as the reason for shifting over to SCHIP; the cost of the family premium through their job was prohibitively high.

Churning in and out of insurance coverage

Uninsured Americans do not form a static group from one year to the next or even one month to the next. There is a group that is consistently uninsured through time, but many more Americans go in and out of various states of coverage.

FIGURE 7B Status of enrollees of the State Children's Health Insurance Program (SCHIP), 2002



* Includes enrollees that found SCHIP coverage more affordable (7.7%), those with a general preference for SCHIP (1.8%), and reason unknown (4.7%).

Source: Sommers et al. (2007).

Tracking people over time, **Figure 7C** demonstrates the extent of shifting in and out of various states of coverage among Americans under 65 from 2001 to 2003. Over a third of the non-elderly are uninsured for at least one month over this three-year period, and a full quarter are uninsured for more than four months. While examining the uninsured at a point in time is useful, it understates the extent to which a larger share of Americans have spells without coverage and it misses the scope of the long-term coverage problem.

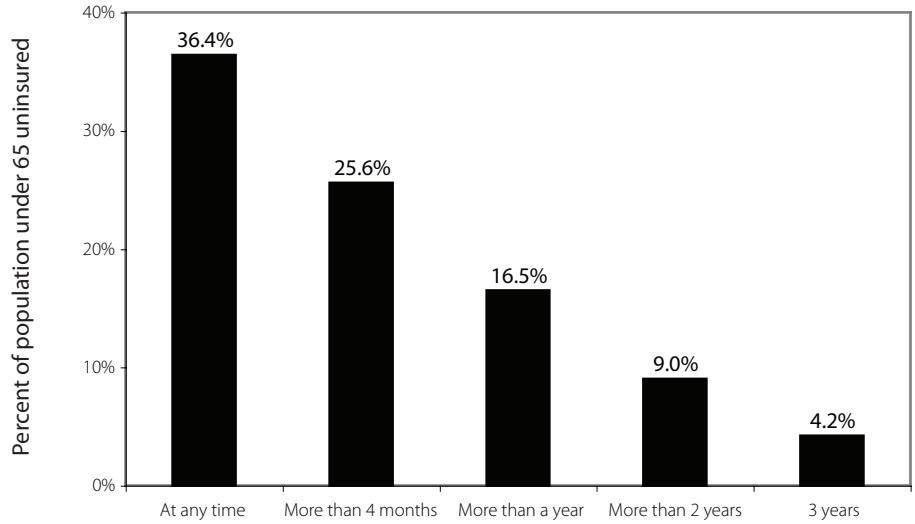
Disparities in health insurance and life expectancy

As shown in Table 7.1, access to employment-based coverage varies by race, nativity, education, and family income. Disparities also exist in access to insurance by type of job, wherein those with nonstandard jobs (part time or part year) have little to no employment-based coverage. This section examines more closely some of these disparities and long-term differences in health outcomes.

Substandard access for nonstandard workers

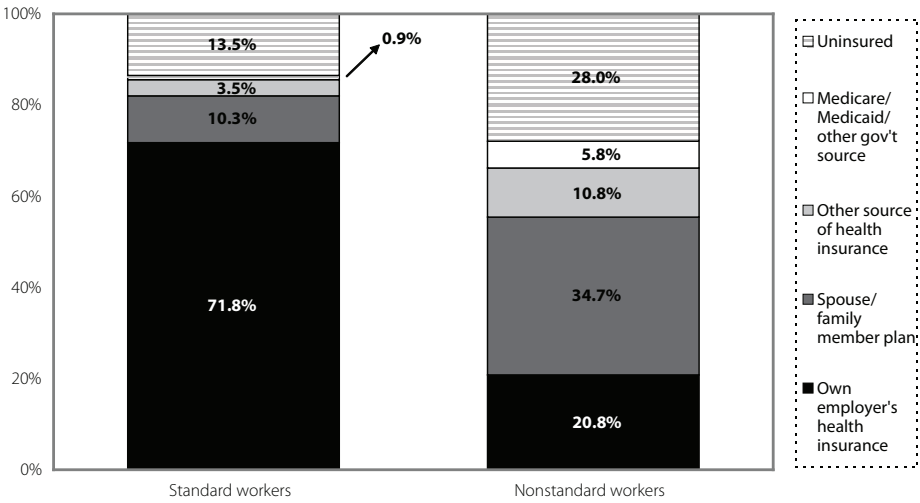
Nonstandard workers, in general, are not only often paid less (see the analysis of part-time workers in Chapter 4), but they also are less likely to receive benefits from their employers and more likely to be uninsured. Nonstandard work includes part-time jobs,

FIGURE 7C Duration without coverage, between 2001-03



Source: Authors' analysis of Bureau of the Census (2001), Survey of Income and Program Participation (SIPP).

FIGURE 7D Source of health insurance, 2005



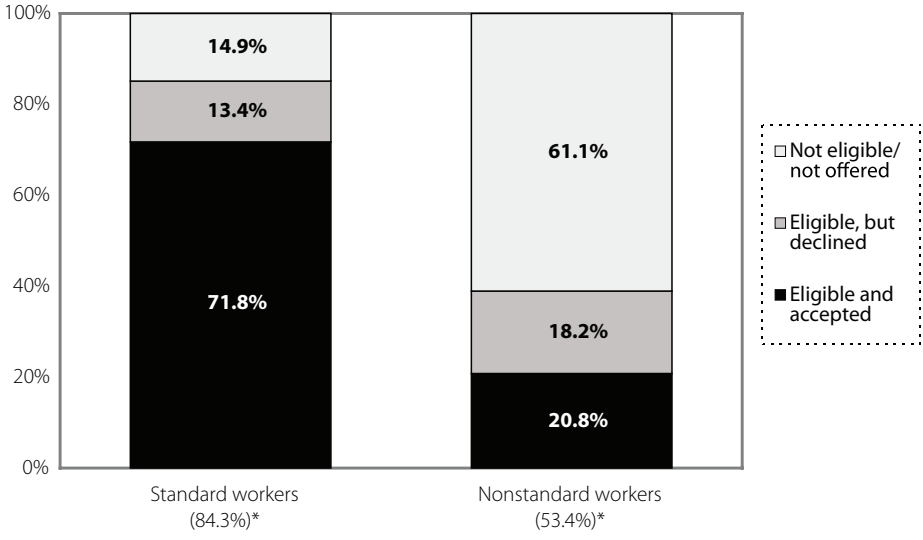
Source: Ditsler and Fisher (2006).

the self employed, independent contractors, and temporary jobs, among others. Over 30% of workers in the United States are nonstandard. **Figure 7D** gives the source of health insurance for both standard and nonstandard workers. Standard workers are much more likely to be insured and to be insured through employer-provided health insurance. In 2005, 86.5% of standard workers were insured, compared to 72.1% of nonstandard workers. Of those percentages, 71.8% of standard workers were insured through their own employer, while just 20.8% of nonstandard workers were. Although nonstandard workers were more likely to receive health insurance from a spouse or other family member's plan, overall nonstandard workers were more than twice as likely as standard workers to be uninsured.

The problem of access to employer-provided health insurance for the nonstandard workforce is clear in **Figure 7E**. In 2005, the majority (61.1%) of nonstandard workers was not eligible for employer-provided insurance, and just about one in five were insured by their employer's plan. In contrast, 14.9% of standard workers were not eligible, and 71.8% were insured through their employer. Many employers fail to provide benefits based on a particular work arrangement, such as denying benefits to part-time workers. This is exacerbated by the fact that many workers are working part time when they would prefer full-time work with benefits (see Chapter 4 for more on this).

Figure 7E indicates that 85.2% of standard workers, but only 39.0% of nonstandard workers, were eligible for employer-provided health insurance from their own employer.

FIGURE 7E Access to health insurance via own employer, 2005



* Health insurance take-up rates in parentheses.

Source: Ditsler and Fisher (2006).

TABLE 7.2 Life expectancy (in years) by socioeconomic deprivation groups*, 1980-2000

	Life expectancy			Absolute difference with 10th decile		
	1980-82	*1989-91*	*1998-2000*	*1980-82*	*1989-91*	*1998-2000*
Both sexes						
Decile 1	73.0	73.9	74.7	2.8	3.5	4.5
Decile 2	73.8	74.8	75.8	2.0	2.6	3.4
Decile 3	73.8	74.8	76.1	2.0	2.6	3.1
Decile 4	74.0	75.1	76.4	1.8	2.3	2.8
Decile 5	74.1	75.4	76.7	1.7	2.0	2.5
Decile 6	73.9	75.2	76.7	1.9	2.2	2.5
Decile 7	74.5	75.9	77.4	1.3	1.5	1.8
Decile 8	74.9	76.3	78.3	0.9	1.1	0.9
Decile 9	75.1	76.4	78.3	0.7	1.0	0.9
Decile 10	75.8	77.4	79.2	0.0	0.0	0.0
Males						
Decile 1	68.7	69.8	71.5	3.8	4.7	5.4
Decile 2	69.8	71.0	72.8	2.7	3.5	4.1
Decile 3	69.8	71.1	73.1	2.7	3.4	3.8
Decile 4	70.1	71.5	73.5	2.4	3.0	3.4
Decile 5	70.3	71.9	73.9	2.2	2.6	3.0
Decile 6	70.1	71.6	73.8	2.4	2.9	3.1
Decile 7	70.8	72.4	74.7	1.7	2.1	2.2
Decile 8	71.3	72.8	75.7	1.2	1.7	1.2
Decile 9	71.5	73.0	75.8	1.0	1.5	1.1
Decile 10	72.5	74.5	76.9	0.0	0.0	0.0
Females						
Decile 1	77.5	78.0	78.0	1.3	2.1	3.3
Decile 2	77.9	78.6	78.7	0.9	1.5	2.6
Decile 3	77.7	78.5	78.9	1.1	1.6	2.4
Decile 4	77.8	78.6	79.1	1.0	1.5	2.2
Decile 5	77.9	78.8	79.4	0.9	1.3	1.9
Decile 6	77.7	78.7	79.4	1.1	1.4	1.9
Decile 7	78.2	79.2	80.0	0.6	0.9	1.3
Decile 8	78.4	79.6	80.8	0.4	0.5	0.5
Decile 9	78.5	79.7	80.7	0.3	0.4	0.6
Decile 10	78.8	80.1	81.3	0.0	0.0	0.0

* Socioeconomic deprivation group refers to a deprivation index based on 11 census-based, county-level social indicators including education, occupation, wealth, income distribution, unemployment rate, poverty rate, and housing quality; 1 being least well-off and 10 being most well-off.

Source: Authors' analysis of Singhl and Siahpush (2006).

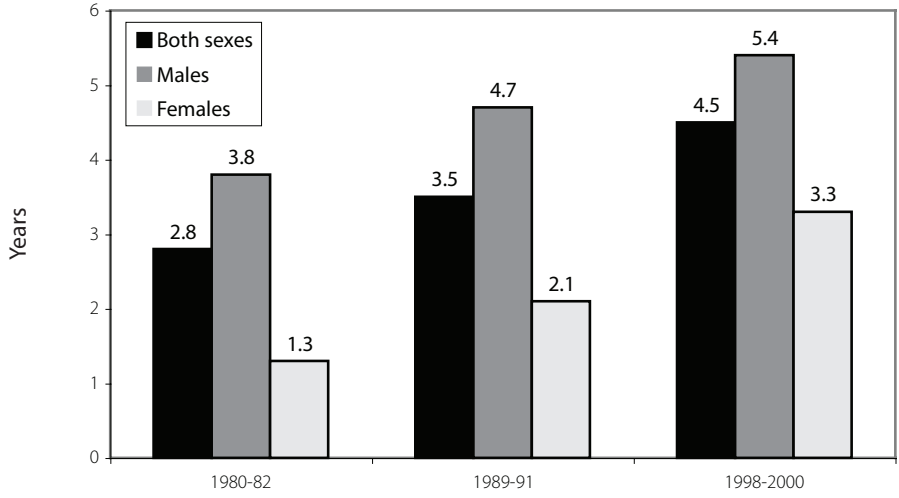
Furthermore, nonstandard workers, even when eligible, were less likely to "take-up" their employer's insurance coverage: the take-up rates for eligible standard and eligible nonstandard workers were 84.3% and 53.4%, respectively (located in parentheses in Figure 7E). The two most common reasons cited for not enrolling in an employer's plan were that workers had coverage from another (probably cheaper or better quality) source, or that the plan being offered was too expensive. (Refer to Chapter 3 for more details on workers health coverage through the job.)

Growing inequality in life expectancy

Having examined the disparities in insurance coverage by socioeconomic status (i.e., family income and education), we now turn to issues of life expectancy. While life expectancy has grown on average across the United States, some segments of the population have experienced more improvement than others. **Table 7.2** compares life expectancy by socioeconomic class, ranked by decile from 1 (worst-off) to 10 (best-off). The data suggest that there are growing disparities in life expectancy by socioeconomic status.

In 1980, the worst-off group had a life expectancy 2.8 years lower than the best-off group (73.0 and 75.8 years, respectively). Twenty years later in 2000, this disparity had grown to a 4.5 year differential. The worst-off socioeconomic group had a life expectancy of 74.7 years as compared to 79.2 for the best-off. This increased disparity, however, was not only found between the extremes of the socioeconomic scale—the

FIGURE 7F Absolute difference in life expectancy between top and bottom decile socioeconomic deprivation groups,* 1980-2000



* See note to Table 7.2.

Source: Authors' analysis of Singhl and Siahpush (2006).

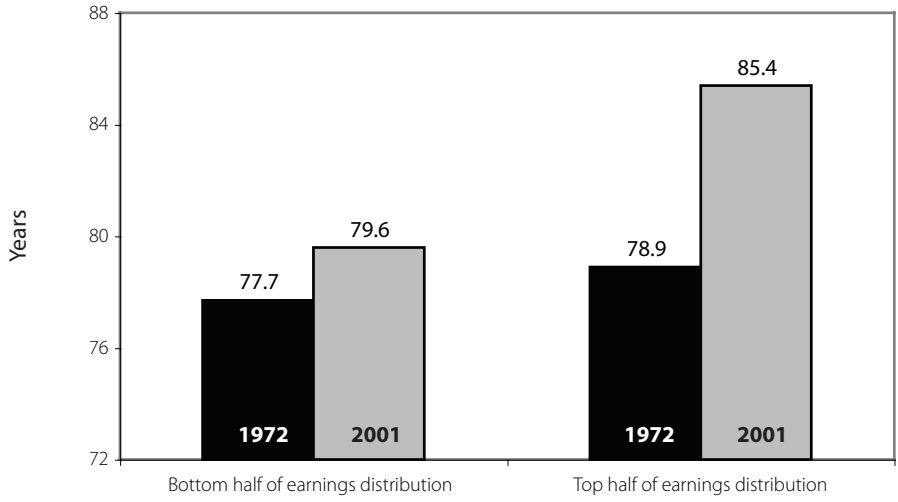
gap between the life expectancy of the middle group (the 5th decile) and the best-off (10th decile) climbed from 1.7 in 1980 to 2.5 by 2000.

When comparing these trends by gender, the evidence suggests that the disparities are higher for males (**Figure 7F**). Since 1980 females consistently had a higher life expectancy than males across the socioeconomic spectrum, although this gender gap had narrowed somewhat by 2000.

Furthermore, research on working men finds that increases in longevity are not balanced across the income ladder. According to a new Social Security Administration working paper (Waldron 2007), a male in the top half of the earnings distribution who turned 60 in 1972 could expect to live 1.2 years longer than one in the bottom half. By 2001, that gap had grown to 5.8 years. **Figure 7G** shows how the growth in life expectancy over the 29-year period was primarily due to longevity advances among the top half of the earnings distribution. These data show that life expectancy for men increased on average by 4.2 years, and that the 6.5 year gain in life expectancy by the best-paid half reaped 77% of the total gains in life expectancy. (It is also interesting to note that Meara, Richards, and Cutler [2008] find growing disparities in life expectancy by education level.)

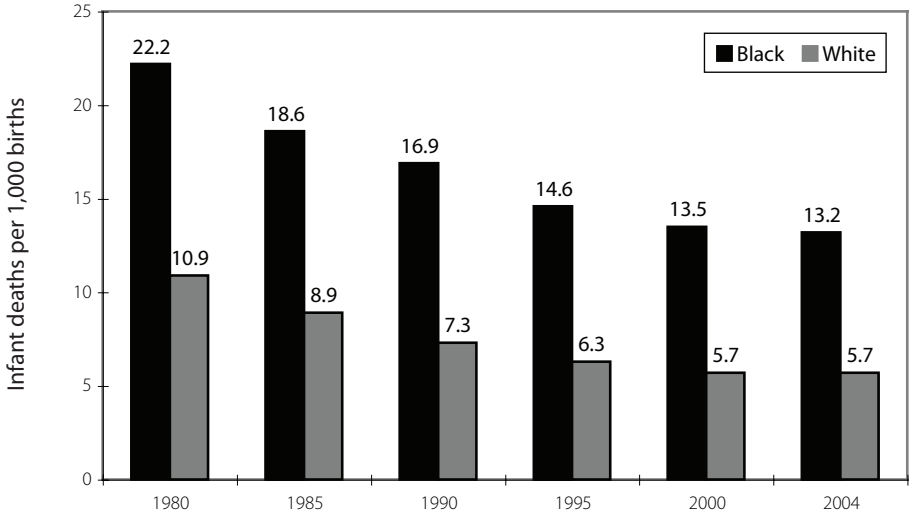
Similar to improvement in overall life expectancy, the United States has experienced significant reductions in infant mortality. As **Figure 7H** shows, although both blacks and whites have seen marked improvements in infant mortality, a large disparity remains. The infant mortality rate among blacks was still 2.3 times that of whites in 2004.

FIGURE 7G Life expectancy for male Social Security-covered workers (age 60) by earnings group, 1972 and 2001



Source: Authors' analysis of Waldron (2007).

FIGURE 7H Racial disparities in infant mortality rates, 1980-2004



Source: U.S. Department of Health and Human Services (2005, 2007).

Health insecurity unequal by race and ethnicity

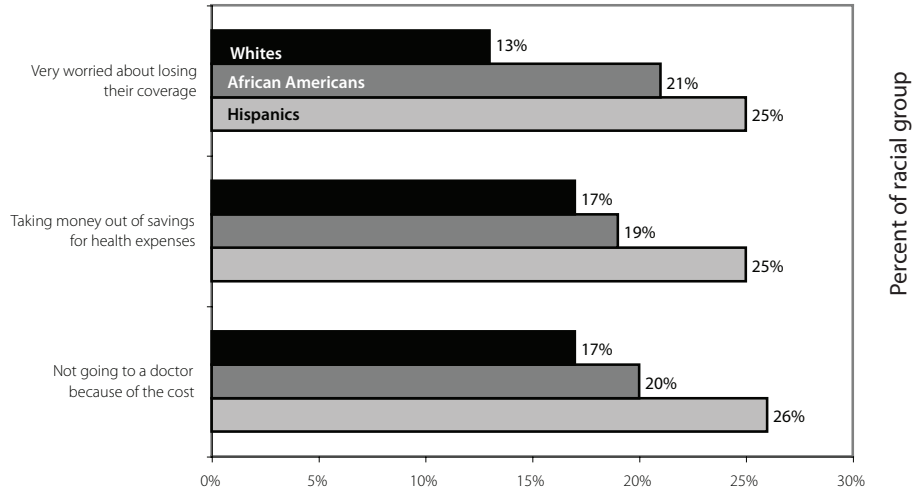
Employer-based health insurance is eroding for all Americans, but among the major racial and ethnic groups, Hispanic workers are the most likely to work for small firms and in industry sectors that do not offer employment-based insurance, according to a recent study by the National Council of La Raza (2008). (Chapter 3 documents their lower coverage on the job.) **Figures 7I** shows that among whites, African Americans, and Hispanics, the latter experience the most health care insecurity. As compared to 17% of whites and 20% of African Americans, 26% of Hispanics do not visit the doctor out of a concern over costs. Hispanics are most likely to take money out of personal or retirement savings to pay for health-related expenses, and among those with health insurance, Hispanics are most worried about losing their coverage. All of these indicators suggest that Hispanics appear to experience the most insecurity when it comes to employer-provided health care coverage.

Thus far we have documented growing insecurity and disparities in coverage. So what explains this increase in the uninsured and the losses in employer-provided coverage? One answer is the rapid growth in insurance and health care costs. The next section details these trends.

Rising costs

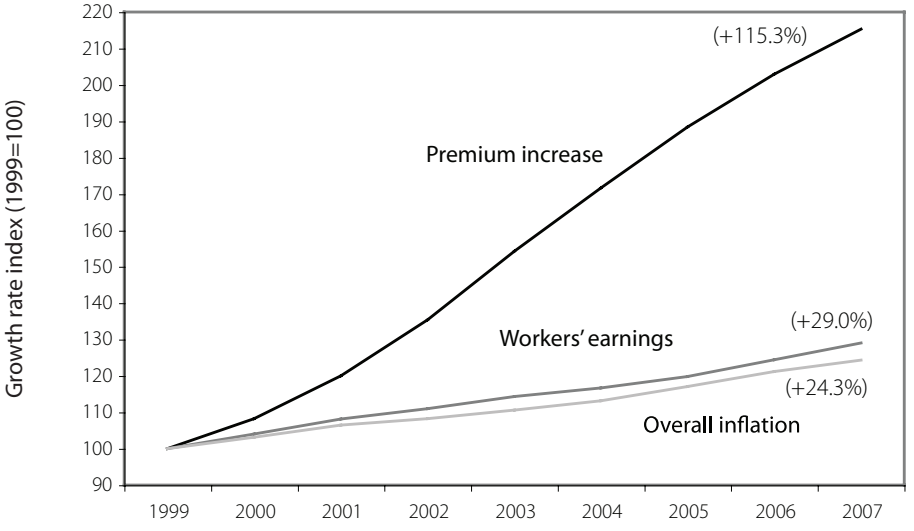
The cost of purchasing employment-based health insurance has grown dramatically in the last several years. As shown in **Figure 7J**, premiums grew 115.3% between

FIGURE 7I Racial differences in health care insecurity, 2007



Source: The Rockefeller Foundation (2007).

FIGURE 7J Growth rate index of health premiums, workers' earnings and overall inflation, 1999-2007



Source: Authors' analysis of Kaiser Family Foundation (2007).

1999 and 2007, a time when workers' earnings only grew 29.0% and overall inflation grew 24.3%.

In 2007, the total cost of the average employer-provided health insurance premium for family plans was $12,106, with an average of $8,824 paid for directly by the working family. Median family income in the United States was just under $60,000 in 2007 (see Chapter 1). While the cost of the premium alone looms large in families' budgets, the premium is only one way that families share in the costs of securing health care. Out-of-pocket expenditures for the purchase of medical care and services, for instance, have also grown. **Table 7.3** combines these costs to illustrate the total family out-of-pocket burden.

The total out-of-pocket burden for a family is measured in comparison to after-tax family income in 1996 and 2003. In 2003, 19.2% of the U.S. population had health care burdens in excess of 10% of disposable income, up from 15.8% in 1996. In other words,

TABLE 7.3 Percent of persons with total family out-of-pocket burdens by insurance and poverty status (under 65), 1996 and 2003

	1996		2003	
	Burden >10% of disposable income	***Burden >20% of disposable income***	***Burden >10% of disposable income***	***Burden >20% of disposable income***
Total U.S. population	15.8%	5.5%	19.2%	7.3%
Insurance status				
Private employment-related insurance	14.2%	3.8%	18.2%	5.5%
Private nongroup insurance	50.0	19.8	53.4	21.1
Public insurance	15.1	8.3	19.4	10.7
No coverage	12.7	6.7	14.5	8.8
Poverty status (% of federal poverty line)				
Poor (<100%)	25.9%	17.7%	33.3%	24.0%
Near poor/low income (100 to <200%)	24.1	6.7	23.7	9.9
Middle income (200% to <400%)	15.6	3.7	22.7	6.2
High income (≥400%)	7.1	1.5	9.7	1.6
Health status				
Perceived health to be fair or poor	--	--	32.3%	15.7%
*Limitations in activities of daily living**	--	--	31.4	15.1

* Pertaining to both physical and sensory activity (i.e., visual and hearing impairments).

Source: Banthin and Bernard (2006).

nearly 20% of the U.S. population spent more than 10% of their after-tax income on health care premiums and purchases of health goods and services in 2003. Burdens in excess of 20% of disposable income were found in 7.3% of the U.S. population in 2003, up from 5.5% in 1996.

Medical cost burdens vary by insurance type and poverty status. The highest burdens are found in families with private, non-group insurance, that is, insurance purchased on the individual market. This is due to the fact that premiums are often higher and coverage is often less comprehensive in the non-group market. In addition, higher cost burdens are associated with fair or poor health; 32.3% of those in fair or poor health spent more than 10% of their disposable income on medical expenses in 2003, and 15.7% spent more than 20%. Those who are both in poor health and have to buy health coverage in the non-group market are doubly burdened.

Table 7.3 also demonstrates that family burdens decline as income rises. One-third of the poor spend more than 10% of their income on health care, and nearly one-quarter spend over 20%. Those with higher incomes spend a much lower percent of their family income on health care; less than 10% spend more than 10% of their disposable income on health coverage, and only 1.6% spend more than 20%. But the poor and high income alike saw increases from 1996 to 2003 in the share of those with serious burdens from health care costs.

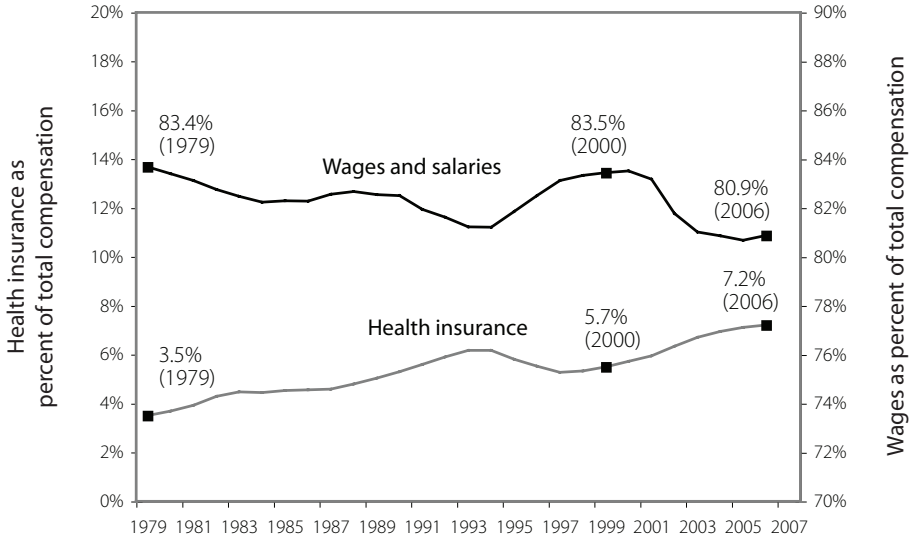
Even for those who are fortunate to have health insurance coverage through their job, the share of premiums paid for by their employer may be crowding out wage gains. From 1980 to 2006, health insurance is shown to eat up a larger part of compensation, as wages and salaries take up less (**Figure 7K**). At the start of the last peak (2000), 5.7% of total compensation was spent on health insurance premiums. By 2006, health insurance spending made up 7.2% of total compensation. This increase occurred as wages and salaries fell 2.5 percentage points as a share of total compensation.

While a one-for-one trade-off would not be expected, higher health costs must be paid for somehow, either by cutting back on other forms of worker compensation and/or reducing firms' profits. That said, higher health insurance costs are not the primary driver for overall wage trends, and they cannot explain the key trends identified in earlier chapters of this book. Certainly health care costs cannot explain any part of the wage stagnation experienced by the 45% of workers who do not even receive insurance through their job (see Chapter 3 on wages). Furthermore, the slowdown in wage growth in this recovery cannot be attributed to health costs, which slowed even more than wage growth (see Figure 7K).

International comparisons

This chapter has demonstrated that one of the most pressing issues in the United States is health insurance and access to health care. But how does the United States compare to other countries in terms of health spending and outcomes? Although the United States spends more on health care than other countries with similar per capita income and populations, it has worse health outcomes, on average. As compared to these comparable Organization for Economic Cooperation and Development (OECD) countries, the United States is the only one without universal coverage.

FIGURE 7K Employer contributions to health insurance and wages as a share of total compensation,* 1979-2006



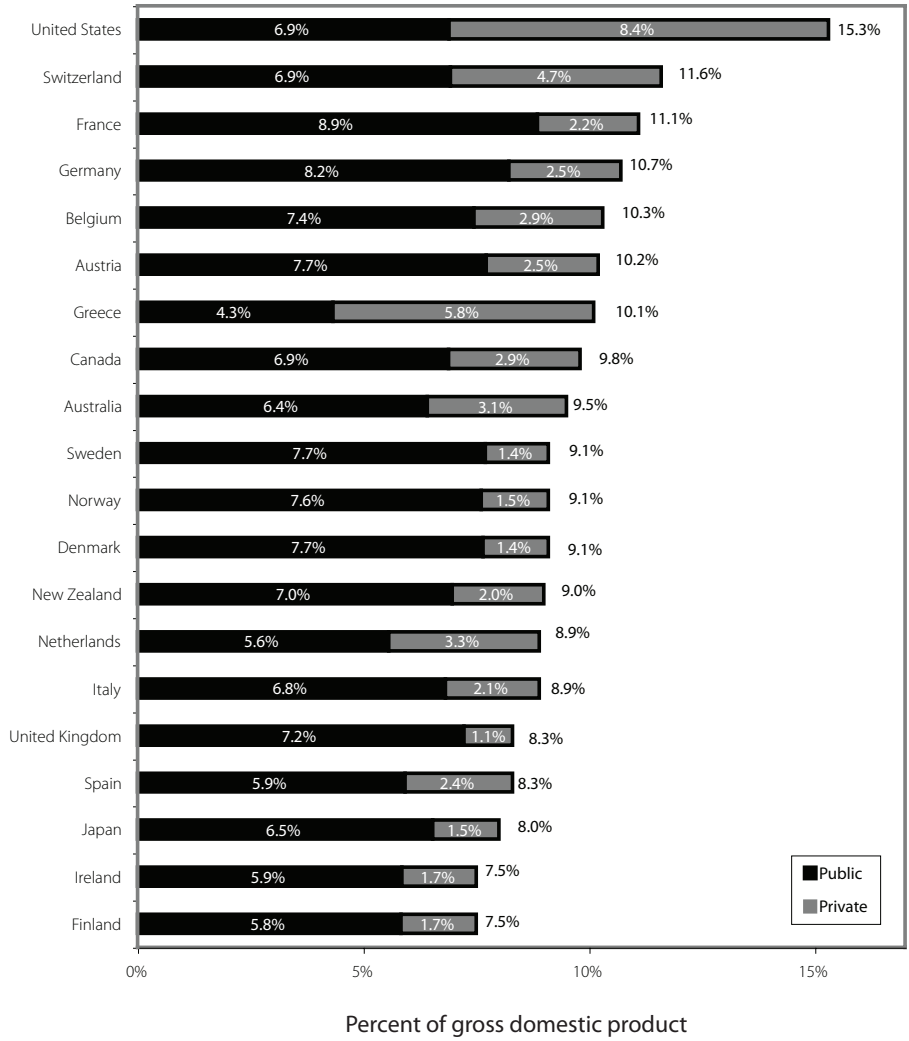
* Total compensation, other insurance, and pension funds.

Source: Authors' analysis of Bureau of Economic Analysis (2008) data.

Americans who have adequate health insurance are provided good health care, but, in the United States, many people have no health insurance whatsoever. In 2006, about 47 million Americans did not have any form of health insurance coverage. As shown earlier in this chapter, the incidence of employer-provided health coverage has been decreasing. At the same time, costs of obtaining coverage and purchasing private health care is increasingly difficult for most low- to middle-income workers, let alone those who are among the unemployed or otherwise disenfranchised. Those with pre-existing conditions or family members with chronic illnesses find it near impossible to purchase adequate insurance on their own.

Figure 7L illustrates the amount of public and private expenditures on health care as a percentage of GDP in 2005. The United States spent more on health care per capita than any of the other countries. In total, the United States spent 15.3% of its GDP on health care—Switzerland (11.6%) and France (11.1%) were a distant second and third. The countries that spent the least were Finland (7.5%), Ireland (7.5%), and Japan (8.0%). Strikingly, it was only in the United States that private expenditures were greater than public expenditures on health care. Overwhelmingly, for the other OECD countries, public expenditures on health care accounted for the majority of overall spending on health.

FIGURE 7L Public and private expenditures on health care spending (as percent of GDP), 2005

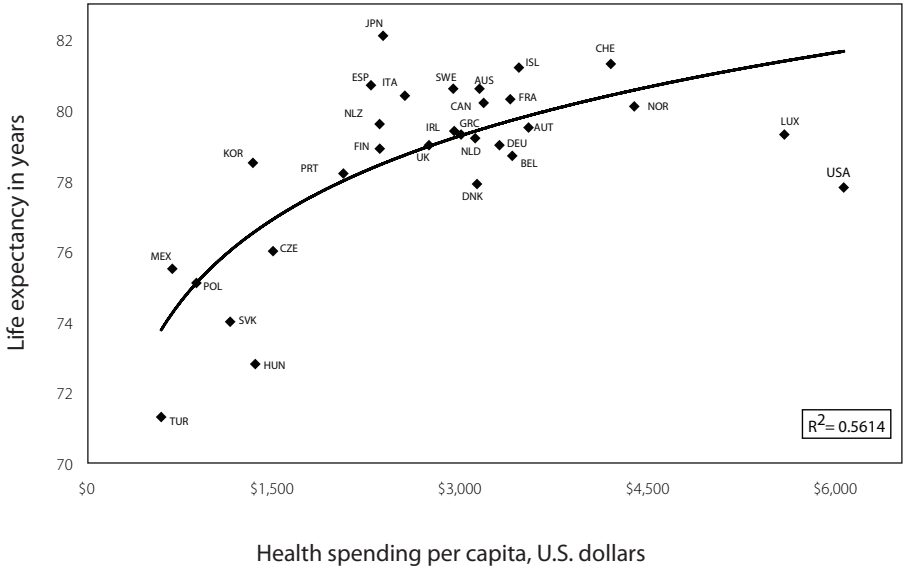


* Any discrepancies in total expenditure are due to rounding.

Source: OECD (2007g).

Of course, health spending is not the whole of health care; it is essential to know the relationship between health care spending and outcomes. Based on OECD data, **Figure 7M** illustrates the simple relationship between life expectancy at birth and per capita health care spending. Higher per capita health spending is generally associated

FIGURE 7M Life expectancy at birth and health spending per capita, 2005



* See the Figure Notes for a guide to the country abbreviations.

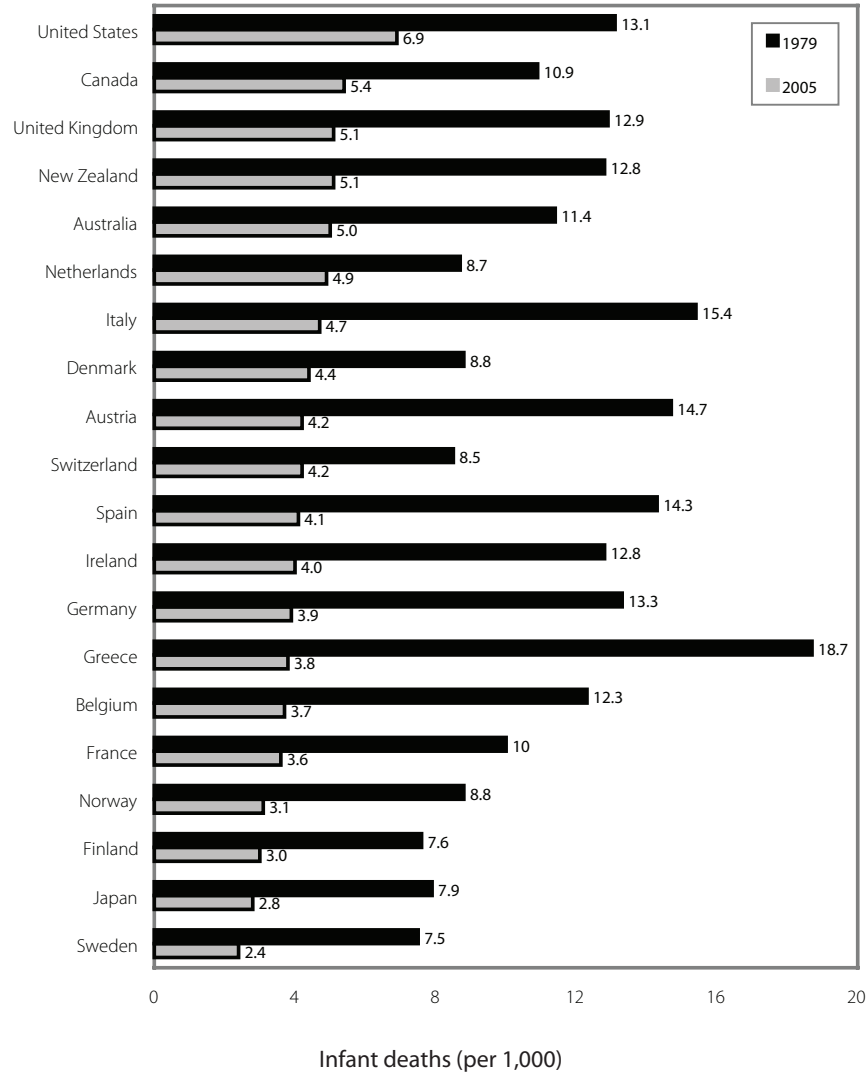
Source: Authors' analysis of OECD (2007g) data.

with a higher life expectancy (as is indicative of the positive slope of the line). However, this relationship tends to be less pronounced with higher per capita spending. The United States was a clear outlier. It had the highest per capita health care spending, but its life expectancy was ranked in the bottom half of all of the OECD countries (not just those of similar size and GDP). The United States spent over twice as much as Japan, but Americans' life expectancy is lower by over four years.

Another important health outcome is infant mortality rate. As **Figure 7N** indicates, in 1979 infant mortality rates (per 1,000 live births) were very high for many OECD countries. The highest rates were in Greece (18.7), Italy (15.4), and Austria (14.7). Moreover, the lowest rates at that time were Sweden (7.5), Finland (7.6), and Japan (7.9)—all of which were higher than the highest rates in 2005. All peer countries made significant progress in reducing infant mortality between 1979 and 2005 (an average decline of 63%). As with life expectancy, the U.S. infant mortality rate—while it decreased by nearly 50% from 1979 to 2005—was the highest amongst these OECD countries in 2005. In 2005, Sweden (2.4) had the lowest infant mortality rate, while Greece, Germany, Spain, and Austria decreased their rates by more than 70% during this period.

Although there are many factors that influence health outcomes, it is clear that the contribution of health care goes a long way in explaining the differences in the health

FIGURE 7N Infant mortality, per 1,000 live births



Source: OECD (2007g).

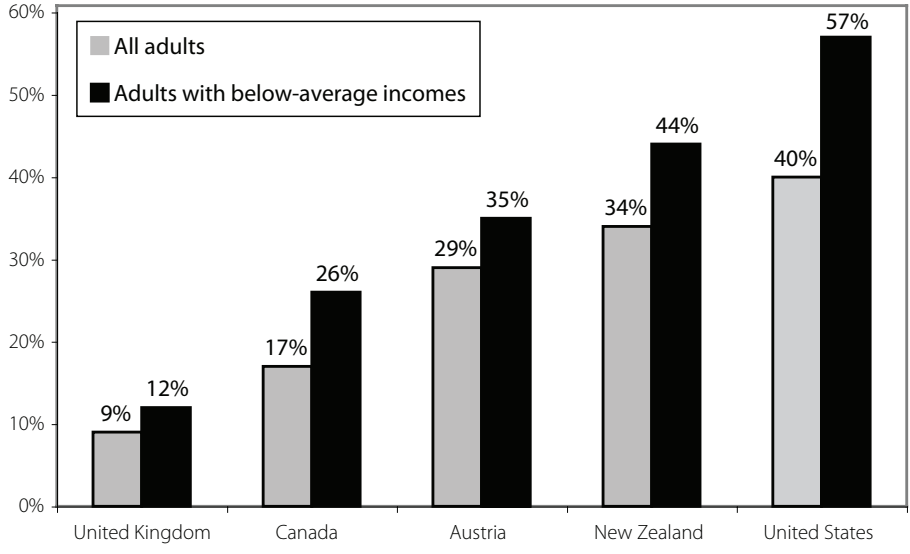
outcomes described here. Many in the United States enjoy premier health care, while others have none. Compared to the Untied States, other countries are more committed to the health and well-being of their citizens through more-universal coverage and more-comprehensive health care systems.

The Commonwealth Fund International Health Policy Survey offers some insight into health care costs and health care received. **Figure 7O** charts responses to a survey question that asked adults whether they went without needed care due to costs. The lighter bars in the figure include responses from all surveyed adults, and the darker bars represent the responses from adults with below-average incomes. Forty percent of adults surveyed in the United States reported they went without needed care due to costs. This percentage increased to 57% for respondents with below-average incomes. For all adults and those with below-average income, survey respondents in the United Kingdom reported the lowest incidence of forgoing needed health care due to costs. This is true despite the fact that the United Kingdom spends a relatively low 7.2% of its GDP on public health expenditures and covers 100% of its citizens. Compared to the United States, all of the other countries surveyed had smaller shares of their population that went without health care because of costs, even though the United States spends a larger share of its national income on health care.

Conclusion

Economic well-being is measured along many dimensions. This chapter detailed troubling trends in health insurance that have only worsened during the most recent recovery. These findings indicate that fewer Americans have access to employment-

FIGURE 70 Percent of adults going without needed health care due to costs, 2004



Source: Schoen and Osborn (2004).

based coverage, that rising costs are eroding family incomes, and that widening disparities exist in insurance coverage and health outcomes by race, income, and education. Costs are rising for both working families and firms, and it is not clear what the United States gains by the money it spends, as compared to other developed countries.