BOOK REVIEW: AFTERMATH OF PRESIDENT JOHNSON’S CRUSADE FOR THE ELDERLY AND IMPOVERISHED

LEGACIES OF THE WAR ON POVERTY. BY MARTHA J. BAILEY, SHELDON DANZIGER (EDITORS); ELIZABETH CASCIO, CHLOE GIBBS, HARRY J. HOLZER, BRIDGET TERRY LONG, JENS LUDWIG, KATHLEEN MCGARRY, DOUGLAS L. MILLER, EDGAR O. OLSEN, SARAH REBER, KATHERINE SWARTZ, JANE WALDFOGEL, AND BARBARA WOLFE. NEW YORK, NEW YORK: RUSSELL SAGE FOUNDATION. 2013. PP. 309. RETAIL PRICE, $39.95.

Reviewed by Justin Doyle*

Many Americans live on the outskirts of hope—some because of their poverty, and some because of their color, and all too many because of both. Our task is to help replace their despair with opportunity. This administration today, here and now, declares unconditional war on poverty in America. I urge this Congress and all Americans to join me in that effort. It will not be a short or easy struggle, no single weapon or strategy will suffice, but we shall not rest until that war is won. The richest Nation on earth can afford to win it. We cannot afford to lose it.

President Lyndon B. Johnson, State of the Union Address, January 8, 1964.1

President Lyndon B. Johnson delivered this speech fifty years ago to the House of Representatives, the Senate, and the world. Since that time, poverty remains one of the most significant problems in our country. Fifteen percent of Americans live in poverty today and currently few signs point to any presidential administration or leadership group addressing the abolishment of this epidemic.2 Some critics believe that the War on Poverty has ended in failure from a health care perspective and has given

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*J.D. Candidate, Suffolk University Law School, 2015; B.S., Bryant University, 2011. Mr. Doyle may be contacted at doylejustin15@gmail.com.

1 MARTHA BAILEY ET AL., LEGACIES OF THE WAR ON POVERTY 1 (Russell Sage Foundation, ed., 2013) (quoting President Lyndon B. Johnson, State of the Union Address (Jan. 8, 1964)).

way to a new era centered on the Affordable Care Act of 2010. The poverty rate in this country is about the same as it was when this “war” was first declared in the 1960s. The majority of the American public viewed President Johnson’s expansive social and health programs as costly overtures and caused many citizens to hesitate when called upon to trust public officials, whom have attempted to implement similar social programs.

*Legacies of the War on Poverty* takes an open-minded look at the War on Poverty and chooses to highlight some of the successes that these implemented programs have achieved over the last fifty years. For example, this publication is quick to suggest that racial discrimination would have escalated without the War on Poverty. In regards to health care and health policy, the book also examines the significant impact that War on Poverty programs, notably Medicare and Medicaid, had on health care as it exists today. Barbara Wolfe and Katherine Swartz, who author the section on the War on Poverty's effect on the United States health care system, agree that Medicaid, Medicare, community health centers, and other health programs increased life expectancy significantly and augmented overall access to health care among the impoverished and elderly.

The overall message in *Legacies of the War on Poverty* is that the War on Poverty was not a complete failure in public administration and social programming as many,
including Paul Ryan and other Republicans have suggested. The authors argue that sophisticated government programs can reduce social hardships such as racial discrimination, lack of health care, and poverty. *Legacies of the War on Poverty* points out that many United States citizens would benefit from the new lessons provided, such as the hardships involved with the introduction of Medicare and Medicaid, in order to accomplish the War's ultimate goal, which was to enhance the lives of those people most in need.

Martha J. Bailey is an associate professor in the Department of Economics and a Research Associate Professor at the Population Studies Center at the University of Michigan. Her work has examined the implications of the diffusion of modern contraception upon women's childbearing and career decisions, and the convergence of the gender gap. Most recently, Bailey has focused on evaluating the short and long-term consequences of Great Society Programs. She received her B.A. in Economics from Agnes Scott College and her M.A. and Ph.D. in Economics from Vanderbilt University.

Sheldon Danziger serves as the President of the Russell Sage Foundation, the H.J. Meyer Distinguished University Professor of Public Policy, and Director of the National Poverty Center for the Gerald R. Ford School of Public Policy at the University of Michigan. His research focuses on trends in poverty and inequality, as well as the effects of economic and demographic changes, and the impact of government social programs on disadvantaged groups. Professor Danziger received

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Fifty years ago today, President Lyndon Johnson declared “unconditional war” on poverty. Depending on your ideological priors, the ensuing effort was either “a catastrophe” (Heritage’s Robert Rector) or “lived up to our best hopes as a people who value the dignity and potential of every human being” (the White House’s news release on the anniversary).


9 Id.

10 Id.

11 Id.


13 Id.
his Ph.D. in Economics from MIT.14

Barbara Wolfe, co-author of the book’s chapters devoted to improving access to medical care and health, is the Richard A. Easterlin Professor of Economics, Population Health Sciences, and Public Affairs at the Robert M. La Follette School of Public Affairs at the University of Wisconsin-Madison.15 She concentrates on poverty and health issues and is currently examining whether housing voucher programs lead to higher earnings as well as the adequacy of resources when individuals retire.16 Recently, Wolfe addressed the effects of welfare reform; ties among income, wealth, and health; racial disparities in health; and intergenerational determinants of success in young adults.17 Professor Wolfe’s recent articles have appeared in the Journal of Public Economics, Journal of Human Resources, International Journal of Health Care Finance and Economics, Journal of Policy Analysis and Management, Economy Inquiry, Journal of Health Economics, and Demography.18 She earned her B.A. in Economics from Cornell University and her M.A. and Ph.D. in Economics from the University of Pennsylvania.19 Wolfe focuses on issues involving Medicaid and Neighborhood Health Centers in her analysis of the effects of the War on Poverty.

Katherine Swartz is a professor of Health Economics and Policy in the Department of Health Policy and Management at the Harvard School of Public Health.20 Professor Swartz’s recent research focuses on the implementation of the Affordable Care Act (“ACA”), aging issues, and episodes of care that involve extremely high cost expenditures.21 She is the author of Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do.22 In the Legacies of the War on Poverty, Swartz articulates why the middle-class is more likely to be uninsured today compared to thirty years ago.23 Professor Swartz was elected to the Institute of Medicine in 2007 and from November 1995 to June 2007 was the lead editor of Inquiry, a journal focusing on

14 Id.
16 Id.
17 Id.
18 Id.
19 Id.
21 Id.
22 Id.
23 BAILEY ET AL., supra note 1.
health care organization, provision and financing. Swartz recognizes throughout her section of the book on Medicaid and Medicare how much these programs have increased Americans overall access to health care while simultaneously reducing the risk of unaffordability.

**Legacies of the War on Poverty Part III: Improving Access to Medical Care and Health**

The focus of the book is an overall analysis of the effects that President Johnson’s War on Poverty programs had on the economy, living standards, and health of the neediest Americans. Part III of *Legacies of the War on Poverty* discusses the mission of the War on Poverty to improve every American’s access to medical care, which is the overall focus of this review. In 1964, the Council of Economic Advisers noted:

[T]he poor receive inadequate medical care, from birth to old age. Additionally, poverty is perpetuated by poor health, malnutrition, and chronic disabilities: Many aged persons are confronted by medical needs beyond their financial means. Passage of the program to provide hospital insurance for the aged under the social security system is an urgent immediate step.

Chapter Nine focuses on the effects of health programs for non-elderly adults and children, while Chapter Ten addresses the impact of these programs on the elderly. Both authors, Katherine Swartz and Barbara Wolfe, agree that even though those living in poverty and the elderly still lack access to the same quality of health care as many middle and upper class Americans, the gap has narrowed since the War on Poverty was declared.

Chapter Nine, authored by Barbara Wolfe, looks at the launch of the Medicaid program, designed to provide health care to children, pregnant women, parents, seniors, and individuals with disabilities living below certain income thresholds, and its impact on American health care over the last fifty years. Wolfe examines the supply side of

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25 Id.
26 Id. at note 1, at 76 (quoting Council of Economic Advisers).
27 Id. at 23.
28 Id. See also Eligibility, MEDICAID.GOV, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html (last visited Nov. 5, 2014) (describing Medicaid program eligibility requirements).
Medicaid, including neighborhood or community health centers, and the demand side, which includes roughly sixty million people receiving Medicaid services. Wolfe concludes that Medicaid, along with the Children’s Health Insurance Program (“CHIP”) and the ACA, have led to increases in life expectancy and also a large reduction in infant mortality. Even in light of these accomplishments, the poor today still remain twice as likely to be uninsured compared to the average American, which Wolfe believes can be changed with the implementation of the ACA.

Katherine Swartz authors Chapter Ten, taking an in-depth look at Medicare, a program that provides health insurance coverage since 1966 to individuals sixty-five and older and the permanently disabled. Medicare Part A is financed primarily through a payroll tax and Part B is funded through monthly premiums paid by recipients and by general federal revenues. According to Swartz, over the last fifty years Medicare and Medicaid have redefined the health and financial risks facing citizens older than sixty-five years old, regardless of income. Some of this redefinition includes how Medicare contributed to the racial integration of hospitals, improved the quality of life for the elderly and allowed increased access to the treatment needed by beneficiaries. Swartz points out, however, that the cost of the Medicare program has outweighed its benefits because increased coverage for medical treatments may have the unintended consequence of increasing medical costs for all Americans, not just the elderly.

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29 See BAILEY ET AL., supra note 1.
30 Id.
31 Id. at 24.
32 Id. In the case of the low-income elderly, Medicaid can cover Part B payments and plays an important role in funding long-term care services, both in nursing homes and in-home health services. Id. See also Medicaid and CHIP Payment and Access Commission, 42 U.S.C.S. § 1396 (2014).
34 BAILEY ET AL., supra note 1, at 26.
35 Id.
36 Id. at 25.

Between 1967 and 1996, Medicare spending grew, in 1996 dollars, from $16
favors restructuring the financing of Medicare and Medicaid and believes that public officials should be open to various options to slow the growth of medical costs which are naturally high in Medicare, given the population of elderly and disabled patients with chronic medical needs.\textsuperscript{37}

\textbf{Medicaid and Other Low Income Programs}

In Chapter 9, Wolfe reminds readers that the health care sector prior to President Johnson's War on Poverty was privately financed, resulting in a meager percentage of the population covered by suitable health insurance.\textsuperscript{38} The federal government subsidized the purchase of employer-sponsored health insurance coverage through taxes and ultimately the aid provided primarily treated those above the poverty line.\textsuperscript{39} The mixture of low usage rates of health insurance programs and the limited supply of health insurance plans resulted in a wide discrepancy in health care provided, with notable discrepancies in coverage based on the race and income of those covered.\textsuperscript{40} According to Wolfe and the statistics she relies on, both life expectancy and infant mortality differed immensely based on race and income over the last century.\textsuperscript{41} Wolfe's assessment parallels Barbara Wolfe's analysis of health care access for low-income citizens across the United States.

Wolfe generally views the introduction of the Medicaid program as a success for the United States and the Johnson administration. She supports this theory by

\begin{quote}
Use of health care was unequal. 4 \textcircled{[sic]} percent of the low-income population but 1 percent of the middle and 0 percent of higher income persons had never seen a doctor; 9 percent of low-income persons but less than 5 percent of middle- and higher-income populations had their last doctor visit more than five years earlier; and only 60 percent of the low-income but 74 percent of the high-income population had at least one doctor visit in the last year, all as of 1963.
\end{quote}

\textit{Id.} at 259.

\textsuperscript{37} \textit{Id.} at 25.
\textsuperscript{38} See \textit{id.} at 259.
\textsuperscript{39} \textsc{Bailey} \textsc{et al.}, \textit{supra} note 1.
\textsuperscript{40} \textit{Id.}
\textsuperscript{41} \textit{Id.}
explaining how more low-income children today are covered by Medicaid through the combination of federal funding and a clearly defined benefit package.\(^{42}\) According to Wolfe, Medicaid was initially designed to cover only children in low-income families, pregnant women, and parents of authorized children.\(^{43}\) Over time, federal rules regarding eligibility have expanded and now Medicaid targets “the neediest and most vulnerable individuals,” including children, pregnant women, people with disabilities and chronic health problems, and low-income seniors.\(^{44}\) The passage of the ACA attempted to expand Medicaid by increasing minimum eligibility levels to include those at 133% of the federal poverty line.\(^{45}\) The Supreme Court declared this portion of the ACA unconstitutional, however states can still opt to expand their Medicaid programs; there are significant benefits for doing so.\(^{46}\) Per Wolfe, the Supreme Court’s decision to strike down Medicaid expansion brought back vestiges of states’ option to provide health insurance coverage to their low-income citizens or, in failing to provide insurance, “perpetuating the existing cross-state inequality for these groups.”\(^{47}\)

In her chapter, Wolfe notes another major program stemming from the War on

\(^{42}\) Id. at 239. All children enrolled in Medicaid are entitled to the comprehensive set of health care services known as Early, Periodic Screening, Diagnosis and Treatment (“EPSDT”). See Children, MEDICAID.GOV, http://www.medicaid.gov/medicaid-chip-program-information/by-population/children/children.html (last visited Dec. 2, 2014). CHIP also ensures a comprehensive set of benefits for children but states have flexibility to design the benefit package. Id.

\(^{43}\) BAILEY ET AL., supra note 1, at 238. “Since its inception, Medicaid has grown significantly. In 2012, it covered around 60 million people, versus about 4 million in 1966, and is the largest source of financing for nursing home and community-based long-term care.” Id.

\(^{44}\) Id. Medicaid is currently the third-largest domestic federal program in the budget, and in most states, is the second largest portion of the state budget. Id. at 239.


\(^{46}\) See 42 U.S.C.S. § 1396a(a)(10). Medicaid offers federal funding to states to assist pregnant women, children, needy families, blind, elderly, and the disabled in obtaining medical care. Id. In order to receive funding, states must comply with federal criteria governing matters such as who receives care and what services are provided at what cost. Id. The ACA expands the scope of the Medicaid program and increases the number of individuals the states must cover. Id. See § 1396a(a)(10)(A)(i)(VIII). For example, the ACA requires state programs to provide Medicaid coverage to adults with incomes up to 133% of the federal poverty level, whereas many states previously covered adults with children only if their income was considerably lower and did not cover childless adults at all. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010) (codified as amended in scattered sections of 26, 42 U.S.C. (2013)). See also Nat’l Fed’n of Bus. v. Sebelius, 132 S. Ct. 2566, 2581-82 (2012) (evaluating constitutionality of Medicaid expansion).

\(^{47}\) BAILEY ET AL., supra note 1, at 260.
Poverty, which allowed low-income children without means to obtain private health insurance and whose families did not qualify for Medicaid. This program was the Neighborhood Health Centers, or as they are known today, community health centers (hereinafter "CHCs").

CHCs operate in low-income areas of the country, providing quality, effective, primary care to low-income residents. Wolfe proclaims that CHCs are vital because they allow low-income citizens access to care, particularly in those states rejecting the ACA's Medicaid expansion. Staffing shortages, including the small number of specialists who are willing to work with low-income patients in impoverished areas of the country is an issue facing CHCs. Wolfe concludes that establishing networks and referral arrangements may be the best option for ensuring that CHC patients have access to the full spectrum of care.

In her conclusion, Wolfe notes how much of the ACA is based on programs established by Johnson's War on Poverty including Medicaid and CHCs. The author believes that eliminating disparities in health care, even with the ACA, continues to be an obstacle because health insurance and access to care are only two of many elements involved in influencing health outcomes. Under the ACA, Wolfe believes that access to health care will increase and financial uncertainty regarding health care will diminish. Even conservative critics should view President Johnson's health initiatives under the War on Poverty as highly successful because of these improvements.

Medicare and Medicaid's Future in an Affordable Care Act World

In Chapter Ten, Katherine Swartz acknowledges that Medicare, with its significant funding, fostered the development of medical treatment options, which

48 Id. at 248. Neighborhood Health Centers were first funded in 1964 under the Economic Opportunity Act to provide health and social services access points in poor and medically underserved communities, both urban and rural, and to promote community empowerment. Id. at 260.
49 Id. at 260.
50 Id. Wolfe consistently reiterates that Community Health Centers should be considered a successful initiative as part of the War on Poverty. Id. CHCs are viewed as significant establishments to provide care to the newly eligible under the ACA. BAILEY ET AL., supra note 1, at 260.
51 Id.
52 Id. at 251.
53 Id. at 260. Other elements are resources, knowledge health-related behaviors, and security purchased through higher incomes. Id.
54 Id. The rate of uninsured for children below the poverty line went from 35% in 1982 to around 10% in 2010. BAILEY ET AL., supra note 1, at 254. Yet the rate for the non-elderly increased from approximately 37% to 40% in the same time frame. Id. at 253. Further, the mortality rate in African American infants dropped from 28% in the 1950s to only 10% in 2007 and similarly, mortality in Caucasian infants dropped from 20% to 5%. Id. at 256.
increased life expectancy and improved overall outcomes of the elderly and non-elderly. According to Swartz, the introduction of Medicare and Medicaid removed financial barriers to obtain medical care, allowing the elderly over the age of sixty-five to obtain treatments which today are seen as the standard of care. Yet the disparity in the quality of health care provided to the elderly based on race and socio-economic status raises additional concerns. As health care costs and life expectancy continue to increase, it has become more challenging for the elderly to save enough income over the years to pay for Medicare Part B premiums and additional long-term care services. This is a troubling trend that Swartz believes could ultimately end up costing both the elderly and today’s younger generations.

In Swartz’s view, there are two main issues to face over the next decade which will affect the United States’ ability to reduce the income disparities impacting Americans’ access to health care. These two issues are the overall impact of the ACA and how the government elects to restructure War on Poverty programs, particularly Medicare and Medicaid, to make the programs financially feasible.

Swartz believes it will take at least a decade before the ACA’s actual effects on the elderly and low-income will be felt, as far as access and quality standards are concerned. Beginning in 2014, the ACA will ensure that almost every citizen under the age of sixty-five will have access to health insurance. Swartz believes this increase in coverage for the non-elderly will reduce some of the health disparities among the elderly over the long term, as well as diminish chronic and preventative medical care costs among the elderly, since they will have had an opportunity to gain adequate treatment

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55 See id. at 25. “Medicare has been enormously beneficial to the elderly for the past fifty years . . . [because] almost all the elderly have health insurance today, which certainly would not have happened if the U.S. had relied on a market for individual private insurance.” Id. at 289.
56 Id. The elderly would never be able to afford such care without the introduction of these programs. BAILEY ET AL., supra note 1, at 289.
57 Id. at 284-85.
58 Id. at 290.
59 See id. at 287.
60 Id. “Some reforms in the ACA will affect low-income people before they reach sixty-five and other reforms are directed at improving the care of elderly poor more immediately.” Id.
61 BAILEY ET AL., supra note 1, at 287. “If low-income non-elderly people have trouble accessing health care even after the ACA is fully implemented, we could continue to see income disparities among the elderly in their health outcomes and use of health care.” Id. See also Where the States Stand on Medicaid Expansion, THE ADVISORY BD. CO. (Sep. 4, 2014), http://www.advisory.com/daily-briefing/resources/primers/medicaidmap. The Supreme Court’s ruling on the ACA allowed states to opt out of Medicaid expansion, leaving each state’s decision to participate in the hands of governors and state legislators. Id. States not expanding Medicaid at this time include Alabama, Florida, Georgia and Texas, among others. Id.
prior to reaching the age of sixty-five.\textsuperscript{62} Experts, including Swartz, believe it will be difficult to see any progress in health outcomes under the ACA for the low-income elderly and results of disparities reduction will not be seen until roughly 2030 because of the number of people involved in the program and the years needed to compile accurate research.\textsuperscript{63}

Secondly, Katherine Swartz addresses keeping health care costs low and having Medicare and Medicaid financially sustainable.\textsuperscript{64} The policy options to slow down the enormous growth in health care spending over the last fifty years are admittedly limited in Swartz’s opinion.\textsuperscript{65} She cannot see a scenario where payments to hospitals, physicians, and other health care providers would be reduced because of the simple, business driven fact that providers will refuse to provide care to low income, elderly patients with extensive medical issues at lower Medicare and Medicaid rates.\textsuperscript{66} Another option to help decrease spending, Swartz writes, is to reduce inefficiencies and overall waste in health care.\textsuperscript{67} Attempts at efficiency under the ACA and by private insurers include increasing the use of electronic health records and implementing organizational changes to increase efficiency in the delivery of care.\textsuperscript{68} Proof that efficiencies will reduce health care spending is many years away because life expectancy has increased over the last few decades, which makes it difficult to anticipate future health care expenditures.

A consequence of living longer is that the elderly will ultimately not have enough money saved at their most desperate times to utilize health care services, according to Swartz and other experts in the field.\textsuperscript{69} Swartz believes that Medicare

\textsuperscript{62} \textit{BAILEY ET AL., supra} note 1, at 287. One problem is that no one knows how the elderly will use health care and how outcomes will shift once someone has health insurance throughout their life. \textit{Id.}

\textsuperscript{63} See \textit{id.} “It will be some time – probably not until the 2030s – before enough elderly will have been covered by health insurance during their younger years for us to know whether such coverage reduces current disparities in health-care use and outcomes among the elderly.” \textit{Id.}

\textsuperscript{64} \textit{Id.} at 287-88. This can be done through “substantially slowing the growth in health-care spending and restructuring the financing of the programs.” \textit{Id.} Health care spending per person in the United States has tripled between 1970 and 2011, and one estimate shows that if health care spending were to grow by one percent faster than the GDP, then 40 percent of per capita income growth would be spent on health care between 2010 and 2050. \textit{BAILEY ET AL., supra} note 1, at 288.

\textsuperscript{65} \textit{Id.}

\textsuperscript{66} \textit{Id.}

\textsuperscript{67} \textit{Id.} “The extent of inefficiencies and waste is estimated to be between 20 and 30 percent of total U.S. health-care spending . . . For comparison, Medicare accounted for 21 percent of all U.S. health care spending in 2011.” \textit{Id.}

\textsuperscript{68} \textit{Id.}

\textsuperscript{69} \textit{BAILEY ET AL., supra} note 1, at 289.
should be restructured to add a pre-funding mechanism in order to anticipate future program expenses and to reassure the younger population that the Medicare program will still exist for their benefit.\textsuperscript{70} She believes that the same fears existing prior to the Medicare and Medicaid programs’ initiation, including the elderly’s worries about not having enough money to pay for health care and long-term services, have been reincarnated fifty years later with growing worries from the non-elderly of becoming impoverished under the ACA.\textsuperscript{71} In one of her most urgent statements, Swartz writes, “research that simulates likely effect of various ways of financing Medicare and Medicaid is urgently needed to reduce such fears and anxieties.”\textsuperscript{72}

From Barbara Wolfe’s point of view, the biggest accomplishment of the War on Poverty health care programs is that they eased the concerns of the elderly and low-income citizens, which existed prior to July 30, 1965. This was a time in the United States when many thought they would not be able to obtain proper medical treatment, due to a lack of consistent access to care or resources. According to Katherine Swartz, the “biggest challenge facing these programs is how to make them financially sustainable for future generations so current cohorts of younger people will not have the fears that people had before Medicaid and Medicare were launched.”\textsuperscript{73} The \textit{Legacies of the War on Poverty} provides readers with a complete overview of the impact of President Lyndon B. Johnson’s programs and initiatives on the United States, both economically and in the health care sector. This book highlights moments in which the United States both struggled and succeeded in providing substantive care to those most in need, but more importantly it highlights the future and the potential turmoil that await. The authors’ opinions are thorough and represent an overall positive picture of the future of the American health care system. A more harsh critique of the Affordable Care Act, including the viewpoints of ACA opponents, would have been helpful. The arguments made by Swartz and Wolfe are highly credible, given their expertise, and most of their analysis in how to incorporate War on Poverty programs seamlessly with the Affordable Care Act is sound. In the end, acceptance of the Affordable Care Act needs to be either complete or nothing at all because the results of optional participation has left War on Poverty programs, like Medicaid and Medicare, in financial and provider accessibility limbo.

\textsuperscript{70} See \textit{id.}
\textsuperscript{71} \textit{Id.} Citizens below the age of sixty-five increasingly worry about paying Medicare and Medicaid taxes with no assurance that the programs will still exist when they reach an eligible age. \textit{Id.}
\textsuperscript{72} \textit{Id.}
\textsuperscript{73} \textit{Id.} at 290.