Introduction

It seems fair to ask, how did I come to write this book? After all, I am a physician, a specialist in hematology, the study of blood diseases. I practiced medicine, led an academic hematology group, and conducted research for 25 years, initially in the Harvard Medical Unit of the Boston City Hospital and later at the University of Pennsylvania, where I also cofounded and directed a cancer center. In 1985, I returned to Milwaukee, the city of my birth, to become dean of the Medical College of Wisconsin, and that started the detour that led directly to this book.

As my deanship was drawing to an end, Bill and Hillary Clinton were developing their health care plan, and it was in this context that I was confronted by two questions that would redirect my career. The first concerned physician supply, and the second concerned poverty, which is the focus of this book. One led to the other, and understanding something about the first will help in understanding why I set out to answer the second. Therefore, I will put the matter of poverty aside for a moment and trace through the antecedent question: how many physicians does the nation need?

Physicians: How Many?

Questions about the appropriate size of the physician workforce had been debated since the late 1970s, but they came to the forefront in 1993 as the Clintons embarked on their "Health Security Act." I was drawn into this fray as a member of the Executive Committee of the Association of American Medical Colleges, the body that oversees the education of MDs. At issue was whether the United States would soon have too many physicians, as was projected by the federal Bureau of Health Professions (BHPr) and accepted by most policymakers. If so, action was necessary to avert a physician surplus (1).

What lay beneath the debate regarding physician supply was another question: why are health care costs rising so rapidly? The conventional wisdom was that physicians and hospitals were the cause and, therefore, there should be fewer, or at least no more, of them. This idea was spawned in 1958 by Milton

Roemer, a US economist working in Canada, who related the number of hospital admissions in various communities to the number of hospital beds. Roemer framed what has come to be called "Roemer's law" of supplier-induced demand: "a bed built is a bed filled" (2). Victor Fuchs, a Stanford health economist, ostensibly confirmed Roemer's law when he reported a close association between the number of surgeons and the amount of surgery (3), but David Dranove and Paul Wehner, economists at Northwestern University, turned it on its head when they found the same relationship between the number of obstetricians and the number of deliveries (4). Surely obstetricians were not causing all of these babies! Nonetheless, generations of economists and health service researchers continued to search for evidence of supplier-induced demand. While some experts have dismissed this phenomenon as trivial (5), others harbor the belief that it is of major importance and, for them, the projected surplus of physicians was alarming.

The question confronting me was whether the projected physician surplus was valid, and the answer proved to be no. The BHPr's projections were wrong in two ways. First, they overestimated the future per capita supply of physicians because they had underestimated future population growth. Second, they underestimated demand because future projections were based on care as it existed at the time, never considering that new therapies and procedures would require more physicians in the future. When these shortcomings were appreciated, it became apparent that, rather than a surplus of physicians, there were likely to be shortages soon after the turn of the century, only a decade ahead (6, 7). In due course, I was able to refine the method of projecting future needs based on trends in the underlying determinants of health care spending (8), but more about that later.

Confronting Future Physician Shortages

While forecasting the future demand for physicians was not difficult, it did prove difficult to change the minds of those who believed in surpluses. Indeed, my "contrarian" findings were not greeted kindly, although they proved to be prophetic. But the dominant view at the time was that there would be as many as 100,000 too many physicians in the year 2000. *New Yorker* cartoons satirized unemployed physicians driving taxicabs. Policymakers pressed for measures to decrease the numbers of MDs being trained. Efforts to do so as part of the Clinton health plan failed in 1994, along with the rest of the plan, but three years later, with support from the major professional organizations overseeing medical

education and practice (9), the Balanced Budget Act of 1997 capped the number of residency positions supported by Medicare—a principal source of support for the postgraduate training of physicians—thereby putting the brakes on further expansion of physician supply.

Despite certainty within the policy community that surpluses would soon appear, the year 2000 was greeted by none, and the years that followed saw deepening shortages. In 2002, I published a paper in *Academic Medicine* entitled "There's a Shortage of Specialists: Is Anyone Listening?" (10). Those who were listening included not only a vast array of state medical and hospital associations but also the same professional organizations that only a few years earlier had called for caps on residency training. Even the Council on Graduate Medical Education, which had been a prime mover in popularizing the BHPr's notion of surpluses, reversed course. Amid an April snowstorm in Washington, DC, in 2004, it changed its long-standing position that there would be 100,000 too many physicians in 2020 to one stating that there would be almost 100,000 too few (11).

Most policymakers were not listening, however, which is why the "caps" have held firm, creating the shortages we have today. But the basis for holding firm ceased to be the BHPr's erroneous projections of physician surpluses. Rather, it was a belief that physician practices are wasteful and inefficient and driven by supplier-induced demand—Roemer's law—and therefore more physicians would be undesirable. It was supported by a growing body of data from the Dartmouth Institute that attributed geographic differences in health care spending among regions of the country to the unwarranted overuse of supply-sensitive services (more on this below). This view was shared by a broad coalition of agencies, foundations, and academics. It unleashed what I have called the "War on Waste" (12), discussed further in chapter 11, and this brings me to the second question that arose as my term as dean of the Medical College of Wisconsin was winding down in the mid-1990s.

Health Care Spending: Why Is It So High?

Initially, this second question was not associated with any national policy issue. It arose in the context of a pragmatic local concern. Why were health care costs much higher in Milwaukee than elsewhere in the upper Midwest? It was being raised by local business leaders who were keenly aware of the impact of health care costs on their bottom lines. Consultants engaged by the business community had tried to find the answer, and now the question was laid before us at the Medical College.

My colleagues and I explored many possible reasons, but it was only when we examined the distribution of costs, neighborhood by neighborhood, that the answer emerged (13). In the 30 years I had been away from Milwaukee, its black population had burgeoned and the city had become the most segregated in the North, more segregated than Detroit. Social problems were legion. We found that patients who resided in Milwaukee's highly segregated "poverty corridor" had hospitalization rates much higher than among those living elsewhere, so much higher that they accounted for the entire excess utilization of care in the Milwaukee region as a whole.

The rest of the Milwaukee story is spelled out in chapter 2, but the critical observation is that Milwaukee's poorest were its sickest and used the most care. This proved to be the rule in other communities, as well. Chapter 1 takes a journey along two subway routes in New York City, where incomes swing from poverty to wealth and back to poverty over the course of only a few stops and where rates of disability and hospital utilization track poverty all the way. Chapter 3 provides a detailed view of Los Angeles, which has more poor people than most cities have people and where low-income patients lift health care costs to among the highest in the nation. And chapter 5 takes us over the border to Canada, where Winnipeg and Saskatoon display the same characteristics. In each case, poverty distinguishes areas where health care spending is high from others where it is low. But a word of caution. Don't blame the victim! Poor patients do not use more health care because they wish to. They do so because their health is poorer and their social circumstances are weaker. The basis for their high health care spending is embedded in the fabric of their lives.

Communal Trends

Individual differences in the demand for health care proved to tell only half the story. When we examined the per capita supply of physicians at the state level, we found a close correlation with the state's economic status (14) (see chapter 8). It turns out that this relationship had existed for more than 50 years, with virtually no change over all of that time (15). My colleagues and I drew upon this observation in constructing a physician demand forecasting model, which is based principally on long-term economic and demographic trends (16). This also led us to the realization that health care spending is related not only to individual income but also to communal wealth (17). States with more resources are able to devote more to health care than those with less, yet in both cases, the demand is greatest among those who are poorest. These two factors come to-

gether in a conceptual framework, which I call the Affluence-Poverty Nexus (18), discussed in chapter 9. But there is another important factor to consider. The United States is a federated republic with a central government. In the beginning, the country cross-subsidized colonies by consolidating the debt that each had accumulated during the Revolutionary War, and it now cross-subsidizes the health care needs of poorer states through Medicare, Medicaid, and other federal programs (discussed in chapters 7 and 8).

That communal resources are a large determinant of spending should not have been a surprise. After all, differences in wealth (measured as gross domestic product, or GDP) correspond closely with differences in health care spending. Chapter 7 explores this phenomenon among the 34 countries that are members of the Organisation for Economic Co-operation and Development (OECD). In recent years, the fact that the United States spends more on health care than expected from its GDP has gained a great deal of attention. Studies presented in chapter 7 sequentially peel away the layers that contribute to this added spending, finally revealing that greater income inequality and inadequate social spending are at its core (19).

It is curious that although the United States is as populous as the combined population of 80% of the other OECD countries, there is a tendency to treat it as though it were as homogeneous as the others. But there are marked regional differences. In a sense, the United States is a nation of nations. Joel Garreau captured the breadth of these differences in *The Nine Nations of North America* (20), and Collin Woodward dug more deeply into their historical and social roots in *American Nations* (21). In chapter 6, I further explore this interesting and important aspect of America. It is difficult to understand the distribution in health care spending in the United States without considering these regional differences.

The *Dartmouth Atlas*

As noted above, when my colleagues and I began to examine why health care costs were higher in Milwaukee, we thought we were addressing a local problem. However, it proved to be part of a national dialog that was unfolding from publication of the studies by John Wennberg and his colleagues, using their newly created *Dartmouth Atlas of Health Care* (22). The Atlas divided the United States into 306 hospital referral regions (HRRs), based on where most patients received most of their care. Dartmouth researchers documented marked differences in Medicare expenditures among these regions (23), and Milwaukee was among those with higher spending. However, the diagnosis made by the Dartmouth

group was quite different from ours. Rather than attributing Milwaukee's higher spending to poverty, they attributed it to the overuse of "supply-sensitive services," reminiscent of the supplier-induced demand that Roemer had popularized. Indeed, in 2005, Wennberg dedicated his Duncan W. Clark Lecture at the New York Academy of Medicine to Roemer (24). He and his colleagues calculated that if higher-spending regions could achieve the efficiency of the lowest-spending regions, US health care spending could be decreased by as much as 30% (25). And in their advice to Congress during the period leading up to ObamaCare (the Affordable Care Act of 2010), the Dartmouth group testified that "given the waste and inefficiency of physician practices, the nation does not need more physicians. Congress should resist efforts to increase the number of residency positions funded by Medicare" (26). In their view, waste was the problem, and that is where Congress should concentrate its efforts in drafting ObamaCare.

The idea that geographic differences in health care spending were due to the overuse of services in high-spending areas had begun even before the Atlas was developed. It grew out of studies of variations among small New England towns, which Wennberg first published in 1973 (27), and it gained momentum after a series of publications in the 1980s and 1990s that compared Boston and New Haven (28). Despite strong similarities between these two cities, each with prominent universities, health care costs were substantially higher in Boston. Wennberg attributed this to Boston's having more physicians and hospital beds, a classic case of supplier-induced demand, and this conclusion caused a "big stir." But when these cities were revisited (chapter 4), it proved to be differences in race and poverty rather than in physicians and hospitals that were the basis for the differences in health care spending.

Why did the Dartmouth group consistently fail to recognize the central role of poverty? After all, they acknowledged that low-income people are sicker and that sick people require more care. Yet they persistently claimed that "regional differences in poverty and income explain almost none of the variation" (29). Others concurred, including influential committees of the Institute of Medicine (30, 31).

One reason for this failure is that Medicare was the metric in all of these studies, but, as discussed in chapters 5 and 8, Medicare spending does not reflect patterns of health care spending overall (17). In addition, the income levels of seniors, the principal Medicare beneficiaries, do not reflect their socioeconomic status to the same degree that incomes do for working-age adults (13). However, the major methodological reason is that the Atlas aggregates all of the data from

all of the people residing within each HRR (see chapter 9). The approximately 1.6 million people in Manhattan and the 10 million in Los Angeles are distilled into single numbers. Economic distinctions between places as different as Harlem and Park Avenue (chapter 1) and South Los Angeles and Beverly Hills (chapter 3) disappear. Indeed, it was only by *disaggregating* HRRs into their constituent zip codes that my colleagues and I were able to discern the enormous impact of poverty on health care utilization in these and other areas (13).

Silencing Poverty

The *Dartmouth Atlas* was not alone in ignoring poverty. Poverty was not on the political agenda in the years leading up to Clinton's Health Security Act, or in the 15 years between that and ObamaCare, or throughout President Obama's first term. Quite the opposite. The Clinton presidency was marked as the era of "ending welfare as we know it," with the transformation of Aid to Families with Dependent Children, established by President Roosevelt in 1935, to a "welfare-to-work" program, eliminating long-term support for millions of mothers and their children. And although poor people were considered in crafting new avenues of insurance in both the Clinton and Obama health care plans, poverty was simply not on the radar screen when considering the causes of high health care spending or its remedies. Indeed, it was difficult during the ramp-up to ObamaCare to converse with legislators or their aides about poverty. The "P" word was unspoken.

Yet poverty was discussed briefly in the years leading up to ObamaCare. In 2007, Senator John Edwards, who also had sought the Democratic presidential nomination, coauthored a book entitled *Ending Poverty in America* (32), and it became the centerpiece of his campaign. That summer, candidate Obama responded by delivering a speech in the Anacostia section of Washington, DC, a profoundly poor area. He called for new assistance for people who live in "dense" or "concentrated" urban poverty, the people whom William Julius Wilson described as "the truly disadvantaged" (33). "What's most overwhelming about urban poverty," Obama said, "is that it's so difficult to escape; it's isolating, and it's everywhere."

Although Edwards continued to speak about poverty, Obama did not. Throughout 2008, neither Obama nor his opponent, John McCain, mentioned poverty in a single speech. It was not mentioned in President Obama's historic Grant Park acceptance speech in 2008, nor was it the subject of a major address during his first term, including both his speech on health care to a joint session of Congress in the fall of 2009 and his last-ditch effort six months later to achieve passage of ObamaCare. Indeed, it was only because of the Occupy Wall Street movement in

2011 that poverty and income inequality entered the national discourse. Nonetheless, during his second presidential campaign, Obama failed to discuss poverty even once during the three debates with his opponent, Mitt Romney. It was not until his second inaugural speech that "poverty" appeared. So it is not surprising that poverty was not integrated into the logic of how the health care system works or what to do about it.

Instead, the president repeatedly pointed to the lower health care spending in small towns, like Green Bay, Wisconsin, and Grand Junction, Colorado, which are devoid of concentrated poverty, never mentioning the dense poverty and high burden of disease in other areas, such as on the south side of Chicago where he had been a community organizer. Seattle and Salt Lake City were offered as models for the nation, while Los Angeles, which has more poor people than these two cities have people, was marked as a place of egregious waste. One could not avoid hearing about the wonders of the Mayo Clinic, located in Rochester, Minnesota, although it is the highest-cost facility in the otherwise low-cost upper Midwest, or about the poor performance of the University of California, Los Angeles, which borders LA's dense urban poverty.

Throughout this period, the silence about poverty was deafening. Its relationship to health care spending is not mentioned once in any of the more than 20 books on health care reform that grace my library shelf, including books by Tom Daschle (34) and Ezekiel Emanuel (35), both of whom advised President Obama, and Glen Hubbard (36), who advised Mitt Romney. Nor was the association between high health care costs and poverty mentioned in T. R. Reid's popular book *The Healing of America* (37) or in his 2012 PBS special *Good News in America*, which presented the good news that health care in communities like Grand Junction and suburban Seattle is less costly than in places like Newark, but failed to point out the glaring demographic differences. Nor was poverty mentioned in a high-visibility statement on approaches to containing health care spending that was published in the *New England Journal of Medicine* in 2012 by Emanuel, Daschle, and 21 other policymakers, including Peter Orszag (director of the Office of Management and Budget), Donald Berwick (Obama's first director of CMS, the agency that oversees Medicare and Medicaid), John Podesta (White House chief of staff during the second Clinton administration), and Uwe Reinhardt and Stuart Altman, two of the nation's leading health economists (38). Yet every physician, nurse, and hospital administrator knows how poverty affects health care utilization. They live it every day.

Poverty, Income Inequality, and Health

It is doubly surprising that health care reform directed so little attention to the relationship between poverty and health care spending given the enormous amounts of scholarship that have been directed to this relationship, starting with Rudolf Virchow's observation in 1848 that poverty and poor education were key factors in the typhus epidemic in Silesia. A growing body of literature since then has described the poorer health status and shorter lives of individuals with less education and lower incomes, particularly those living in dense urban barrios or ghettos, a disproportionate number of whom are members of racial or ethnic minorities. The term that came to be applied was *health inequality*. But although poverty has been linked to *poor health*, its link to *higher health care spending* has been less conspicuous.

One reason that poverty may not have been considered as a cause of higher health care spending is that it really wasn't a cause 30 to 40 years ago. During the 1970s and 1980s, average costs for low-income patients were less than those for wealthy patients, and they were lower still for the poor elderly before Medicare was passed in 1965 (39). However, with broader insurance coverage and more sophisticated care, these differences narrowed. By 1992, when Bill Clinton was elected, health care spending at the two ends of the income spectrum had reached parity, and by 2008, when President Obama was elected, Medicare spending was 30% to 40% greater among poor beneficiaries than among wealthy ones (40) (see chapter 5).

Beginning in the mid-1990s, John Billings, at the United Hospital Fund in New York, reported that hospital admission rates for chronic conditions were four to five times higher among patients from poor zip codes in New York than among those from rich ones, and the same was true in other large metropolitan areas (41, 42). At the same time, Noralou Roos and Cameron Mustard reported similar observations in Winnipeg and other Canadian cities (43) (described in chapter 5). And by the end of the 1990s, my colleagues and I had uncovered the enormous contribution of poverty to the high health care spending in Milwaukee (chapter 2) and, later, in Los Angeles (chapter 3) (16). Nonetheless, poverty was not on the radar screen of health care reform as ObamaCare was being crafted.

Opinion Leaders

What policymakers did have on their radar screens was that deficiencies in clinical practice were the principal cause of excess spending and poor outcomes.

In their view, much of the sophisticated and expensive care that specialists were providing was unneeded, and this was driving up costs. By the time President Clinton entered office in 1992, constraining the growth of specialization was seen as a key to controlling health care spending, and after the demise of the Clinton health plan, this philosophy continued to flourish within influential foundations and organizations and among the individuals who led them. Among them were leaders of the Robert Wood Johnson Foundation, the largest medical foundation in the United States, who had singled out specialty distribution of physicians as the "the invisible driver of health care costs" (44).

In the late 1990s, the Robert Wood Johnson Foundation financed the development of the *Dartmouth Atlas* (22), which spawned the notion that the "unexplained" variation in health care spending among regions of the country was due to unwarranted excesses of specialty services (23). Possibly, no publications drawing on the *Dartmouth Atlas* had more influence on establishing this concept than a pair of papers by Elliott Fisher and his colleagues in the *Annals of Internal Medicine* in 2003, which concluded: "If the United States as a whole could safely achieve spending levels comparable to those of the lowest, annual savings of up to 30% of Medicare expenditures could be achieved" (25).

As mentioned above, the methodological details underlying this conclusion are deeply flawed. Nonetheless, the conceptual framework it created was greeted with resounding approval. It was echoed by the Dartmouth collaborators, who claimed that states with more specialists and higher spending had lower-quality care (45), and by Barbara Starfield, an expert on primary care, who claimed that mortality rates were higher in states with more specialists (46). The Commonwealth Fund joined this refrain with reports showing that unexplained variations in quality and mortality existed not only among states (47, 48) but among nations and that, despite its greater spending, the United States performed worse than other countries (47, 49).

The conceptual framework that flowed from this resonated with the Medicare Payment Advisory Commission, which advises Congress (50), and it found a home in the Institute of Medicine (IOM), a prestigious organization whose members are leaders in American medicine. In 2001, the IOM published its seminal report *Crossing the Quality Chasm* (51), which characterized US health care as unsafe, inconsistent, and wasteful, and it called for major structural reform. In follow-up reports in 2010 (52) and 2012 (53), the IOM further popularized the notion that 30% of US health care spending is wasted. Curiously, it ignored the

possibility that poverty may be a contributory factor. Indeed, in more than 1,500 pages of the IOM's several reports, "poverty" was not mentioned even once, while "waste" was mentioned more than 250 times. Even in its 2013 report on geographic variation in health care spending, the IOM failed to mention poverty as a possible factor and referred to the impact of income on health care spending as "trivial" (30).

This body of work, flowing as it has from multiple respected sources, has been taken as "evidence" that more specialists and more spending add no value and that 30% of health care spending is wasted. Yet when viewed through the lens of poverty, each line of "evidence" proves to be a manifestation of the increased care required by patients who are poor (13, 14, 17, 19) (see chapter 9). Call it waste if you want. Treating a homeless man's frostbitten toes is surely a waste, when a pair of shoes could have prevented it.

An Attempt to Set the Record Straight

In 2009, while health care reform was being debated, I called attention to this contradiction in an op-ed in the *Washington Post*, entitled "The Wrong Map for Health Care Reform" (54). Over the years since then, I have posted countless numbers of essays on my blog discussing the contributions of P-O-V-E-R-T-Y to high health care spending (55). Nonetheless, policymakers have consistently ignored poverty; in fact, they have repeatedly denied that it contributes significantly to the observed variations in health care spending (29–31, 52, 53).

One of my all-time favorite movies is *The King and I*, the 1956 screen adaptation of the brilliant Rodgers and Hammerstein musical, starring Yul Brynner and Deborah Kerr. The discussion above brings to mind a line spoken by the king, who was grooming his son to some day succeed him. He said, "Tho' a man may be in doubt of what he know, very quickly he will fight to prove that what he does not know is so." And so, "what is not so" has become a centerpiece of health care policy. Policymakers have built what I have termed a "quality-industrial complex" and have concentrated on transforming the structure of clinical practices rather than on building a social infrastructure that could enable poor patients to lead healthier lives, better cope with disease, and escape from the cycle of poverty (chapter 11). As the social epidemiologist Nancy Krieger admonished, "Blot poverty from view and not only will we contribute to making suffering invisible but our understanding of disease etiology will be marred" (56).

ObamaCare

It may be difficult to believe that poverty has been blotted from view. After all, ObamaCare is meant to help poor people, and it does. It expands Medicaid eligibility for many who are poor, creates federally subsidized insurance exchanges for others who are near-poor, and funds an expansion of community health centers, which serve poor people. The American Recovery and Reinvestment Act, which preceded it, also helped people living in poverty by funding food stamps, food banks, and the nutrition program for women, infants, and children (WIC), by aiding neighborhood stabilization and homelessness prevention programs, and by increasing child tax credits. And the president has proposed additional measures, such as counseling for low-income mothers and in-school meals for low-income children.

But the goals of ObamaCare were not only to reduce the number of uninsured and increase the fairness of health insurance; they were also to slow the growth of health care spending, with the hope that success in constraining spending would provide the necessary funds. With more than 400 separate sections, ObamaCare is by far the most comprehensive piece of health care legislation in the history of the nation—more even than the Social Security Amendments of 1965, which in less than one-tenth the space gave birth to Medicare and Medicaid. However, unlike ObamaCare, this earlier legislation was simply an insurance bill. It did not address the practice of medicine. In fact, a disclaimer in the bill stated that "nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine." Even the Clinton health plan, which also set up a new health insurance system, adhered to that dictum. But in its quest to narrow the 30%, ObamaCare deviated sharply from this policy. According to Brookings Institution health economist Henry Aaron, it included "virtually every cost-control idea that anyone has come up with" (57), but it is not clear how many of these will achieve their intended purpose.

Having conflated wasteful clinical practices with the added costs of poverty, ObamaCare created a system of regulations, incentives, and penalties to attack what it saw as the problem (chapter 11). But it was blind to the socioeconomic factors that underlie high health care utilization. For example, it established penalties for hospitals with "excessive" numbers of hospital readmissions, ignoring the reality that most readmissions are of poor patients, and it imposed penalties for higher 30-day mortality rates, failing to recognize that it is the poorest who have the highest rates. Believing that more poor patients will be insured, Obama-

Care has reduced federal disproportionate share payments, which aid hospitals with a high census of low-income patients, whether or not they are insured. Health care providers attempt to deal with the fallout, but policymakers seem oblivious to their needs. Indeed, instead of strengthening the ability of providers to care for poor patients, they are trying to restructure the health care system into something it cannot be.

The Challenge Ahead

The inescapable conclusion is that the United States will not be able to constrain its spiraling health care spending without addressing the high costs of caring for patients at the bottom of the economic ladder. But how? Answers to a problem are most often sought within the problem, and there is merit in doing so. But answers often reside outside the problem. That is true in this case. The high costs associated with poverty will continue to overwhelm the system, no matter how it is structured and improved. As discussed in chapter 10, greater attention must be directed to activities that exist beyond traditional health care, such as housing, transportation, and social support (58), which have been shown to reduce costs and improve outcomes (59). At a broader level, what is needed is a reduction in income inequality and the creation of a social infrastructure that enables low-income families to exit from the cycle of poverty. For all of its efforts and successes in the past, the United States has not done enough. By all appearances, poverty is a war that it has not wished to win. *But the United States does not and will not have the resources to provide equitable, cost-effective care for those who confront inequitable circumstances in every other aspect of their lives.*

Countries like Sweden, France, and Japan have made the creation of a strong social infrastructure a national goal. In contrast, social spending in the United States relative to its economic capacity is among the lowest of all developed countries (see chapter 7) (60). Those countries that view social equity as a priority have approached the problem broadly, through investments ranging from housing, neighborhood safety, public transportation, and food supports to job training, adequate wages, and sick leave. Programs have been created that nurture the ability of mothers to nurture their children. And investments have been made in education, from preschool through high school. As a result, income inequality has narrowed, health inequality has diminished, and health care spending has been controlled.

No less is necessary for the United States. Without it, no amount of health care spending will permit all Americans to lead the long and healthy lives they

desire, and health care spending will continue its unsustainable upward spiral. How does one begin to reverse this spiral? The starting point is to understand how poverty and health care interface.

In that timeless movie *The Wizard of Oz*, Dorothy has faith that the Wizard will be able to control the balloon in which he is departing and return for her. But to her shocked disappointment, the Wizard calls out, "I can't come back. I don't know how it works. Good-bye folks!" That can't happen here. Policymakers and the public must know how poverty and health care work. It is the goal of this book to ensure that they will.