



NEGATIVE POPULATION GROWTH

THE NPG FORUM

Demography and Health Care Reform

by Lindsey Grant

The President's proposal for a national Health Security Act must deal with an aging population structure, problems involving immigration, fertility, AIDS and perhaps other plagues, and a changing labor force. Those issues will affect the proposal in ways that may not be immediately apparent and that were not discussed as the plan was offered. They deserve attention, because they could endanger the plan if they are not considered.

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Joseph Califano (who was there when it happened) has recently given a vivid description of the way in which President Johnson and Wilbur Mills created Medicaid and Medicare and of their failure to address either the demographics of an aging and changing society or the costs of the proposed programs.¹ He was not being critical. We have something of a national habit of understating the difficulties when we want to do something, and national health care is an idea whose time seems to have come.

Perhaps this time, when people are coming to sense that perpetual growth is not necessarily the natural order of things, we should take a serious look at some of the constraints on the proposed program.²

Two key points emerge: first, Congress should be very cautious about any proposal to create further **entitlements**. The costs of the proposed program could escalate beyond the nation's ability to pay. While keeping the principle of universal coverage, the government should preserve room to draw limits as to how much can be spent on each individual. Second, the issuance of National Health Cards could become riddled with fraud unless the country finally faces up to the need for a **secure system of identification** — i.e. the ability to tell who a person is. The development of such a system would help to control illegal immigration, drug smuggling and terrorism, aside from making it possible to know who is entitled to health care.

Multiplication of the Elderly

The chart shows the anticipated growth of the elderly. Count on it. Only a plague will keep people from getting older.

A rise in the elderly population is natural and indeed inevitable for any nation as it gets off the population growth treadmill. It is not necessarily a problem.³ However, we must anticipate a particularly sharp rise from 2010-2030. It represents the last hurrah of the post World War II baby boom. (Any enthusiast for population growth should consider that poor generation: from crowded schools to trouble finding jobs in the '80s, to the layoffs and deteriorating job structure of the '90s, finally to become an unappreciated burden a few years hence.)

Look at the graph. That is quite a curve. Moreover, the numbers of the "old old" — those 80 and over — will grow even more sharply and will peak a decade or so later. They are the ones who will require the most care.

This trend is unsettling partly because care of the elderly is now borne in large measure by government, as a result of the societal shift away from support by the old folks' children (accentuated perhaps by Medicaid and Medicare, which made an alternative care supplier available). This means, one way or another,

er, that the support comes out of taxes. Moreover, this charge will probably fall largely in the public sector of the health plan rather than in the component that is to be hidden in the proposed increase in charges to employers. It will add to other forces tending to expand the publicly supported portion of the program.

The cost of the program will escalate rapidly in decades to come, particularly since it is planned to include prescriptions, long term care, and treatment for the diseases of the aged, which can be very expensive. The plan's proponents say that long term care will "emphasize home- and community-based care". A laudable goal, but it bucks the recent trend in behavior. At least, we may hope that the planners are aware that they have a problem.

The issue should not be swept under the rug, as happens so regularly when advocates of particular legislation understate the out-year costs.

AIDS and Plagues

The politicians are going to hate to have to face this one.

Reported AIDS cases rose from 4442 to 43,672 from 1984 to 1991, and an additional 89,804 cases have been reported since then, with 180,000 cumulative deaths reported. The number of HIV-infected persons is unknown, but estimated at one million. Infection rates seem to be declining among gay white men 25-44 years old, but rising among younger gays, drug users and — particularly — women.⁴

In 1992, AIDS cases rose 2.5 percent among men, and 9.8 percent among women.⁵ That is an ominous

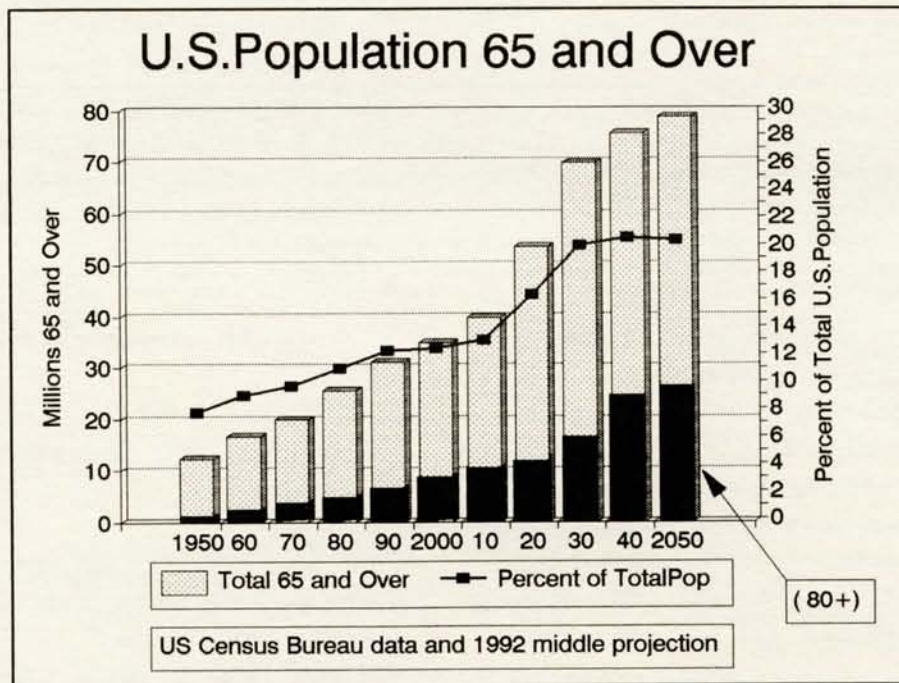
shift. It suggests that AIDS is moving from gays and intravenous drug users into the larger general heterosexual population.⁶ Perhaps we are more like Africa than we thought. There, the incidence has always been heterosexual, and in four countries it exceeds 5 percent of the total population. At that rate, the U.S. would have more than 12 million AIDS patients.

Perhaps even more ominous, the epidemic in the U.S. is growing fastest among the young. One expert reported that AIDS cases among adolescents had risen 77 percent in the last two years.⁷

AIDS is a particularly insidious epidemic, partly because of the ten year average incubation period. Barring a cure that is not yet in sight, we may anticipate an explosive growth of a very expensive class of

potential health care recipients. Like care for the elderly, this expense will probably tend to fall in the public sector of the health program; employers will do everything they can to avoid it.

AIDS is not the only problem on the horizon. The popular press seems largely to have missed the story, but there has been a fundamental erosion of confidence within the scientific community as to whether we can handle other infectious diseases. Humankind is being subjected, in a sense, to a counterattack in a war that we thought we had won. The U.S. Surgeon General in 1969 told Congress that the war against infectious diseases was effectively finished. Now we are watching the resurgence of a number of treatment-resistant disease strains: cholera, tuberculosis, hantavirus. The pathogens are learning to handle the poisons and antibiotics that our race launched against them a generation ago. A *Science* magazine editorial called it a "subterranean war" and said that



“Those who believed a plague could not happen in this century have already seen the beginning of one in the AIDS crisis, but the drug-resistant strains in this issue [of the magazine], which can be transmitted by casual contacts in movie theaters, hospitals and shopping centers, are likely to be even more terrifying...”⁸

This raises a question whether Congress should be passing an entitlement program to cover a future that is very far from clear. Other entitlement programs have been a potent force driving our budget deficit in the past two decades because their size is dictated by demand (as defined in the legislation), rather than by the budgetary process. The nation may find that it cannot do all it would like for everybody, whether the old or the plague patient, and it may need the flexibility to address the questions: “What are the priorities? If forced to it, how can we best use each medical insurance dollar? Should we, for instance, try to underwrite extremely expensive operations for the elderly, or when the odds against full recovery are not very good?” Oregon has led the way in addressing these questions, and to its credit the Clinton administration (unlike its predecessor) has allowed it to proceed with the experiment.

The Magnet Effect

The AIDS epidemic, with the possibility of others to come, raises some important questions about immigration policy.

AIDS cases worldwide are projected to quintuple to about 10 million by 2000.⁹ In Haiti, 7 to 10 percent of adults have HIV, the forerunner of AIDS. Haitians with HIV have been brought into the U.S. by court order. Congress has now voted resoundingly to forbid the immigration of HIV-infected persons, and the President signed the bill despite his campaign statements in favor of admission. It is far from certain that the decision will stop the movement. The availability of free hospital coverage for AIDS in the U.S. will attract HIV sufferers in less generous lands and, given the casual way we enforce our immigration laws, many of them will probably be able to get here.

Perhaps it sounds heartless. One would like to be able to help everybody, everywhere. There is, however, a conflict between moral obligations, and it is driven by the reality that resources are not infinite. We may well

have trouble in doing what we would like for our own people in the years ahead.

There is a widespread misapprehension that third world population growth, the chief engine of migration to the U.S., is waning. On the contrary, it is intense and growing. The second graph shows the ongoing growth of the working age population in the so-called third world. Most of the third world suffers already from massive unemployment. Witness the desperate efforts by Chinese to get to the U.S. even in the midst of a touted economic boom, or the approval of a governmental “overseas employment agency” to help Chinese to emigrate.¹⁰ Migration is the only hope for a decent living for many or most of the people represented in that graph. Only in eastern Asia and some Caribbean islands has fertility fallen enough to offer some confidence that the pressure will disappear some day, and even for most of those areas the relief is a long way off, because the labor market entrants of two decades hence are already born.

I do not mean to suggest that those billions of people will all suddenly decamp for the United States. If one-tenth of them did — a proportion much smaller than the exodus from Europe to the New World in the nineteenth century — it would double our population. That presumably would make the U.S. about as attractive to job seekers as India, thus discouraging the rest.

In a world that is approaching intolerable crowding, the United States is not immune. We are already heading toward 400 million around 2050 — 140 million more people in about 60 years.¹¹ Most of this growth will result from immigration, because the pull of our relative prosperity is very strong for the poor elsewhere.

Post-1900 immigrants and their descendants have contributed 43 percent of the trebling of U.S. population so far in this century. Post-2000 immigrants and their descendants are projected to contribute 73 percent of the population growth during the first half of the next century. This assumes, conservatively, that annual net immigration is about one million and will stay there. If it continues to increase, our population is headed well past 400 million by 2050.

The connection with health reform is not simply about whether to take in very expensive immigrants such as those with HIV. It involves the question whether

the health care package may encourage immigration and thus population growth. The administration has decided to limit the benefits to citizens and legal residents. HUD Secretary Henry Cisneros, a strong figure in the Cabinet and leading Hispanic, says we should deny health and welfare benefits to illegal aliens.¹² Presumably, the benefits would not be available to non-immigrants, of whom there are about 20 million every year. (Although it has not been said, one assumes that both groups will continue to get treatment for contagious illness and emergency care, for humanitarian reasons and the protection of others.)

The question is whether the nation can make that decision stick. No one can seriously pretend to predict the effect of improved medical services in promoting immigration, legal and

illegal. However, we must assume that, added to food stamps and other sources of welfare, health care will constitute another strong inducement to come here or, once arrived, to stay. Already, the practice of crossing the border for treatment in welfare hospitals is well established. The proposed government program will cover the jobless and those in the sorts of jobs that tend to be filled by illegal immigrants. Many may agree with the illegal alien who had just lost his job but told a reporter "it's still better than where I came from."

The point here is that the health care package may generate another strong inducement to illegal immigration, and in the process it will drive up the cost of the health care itself.

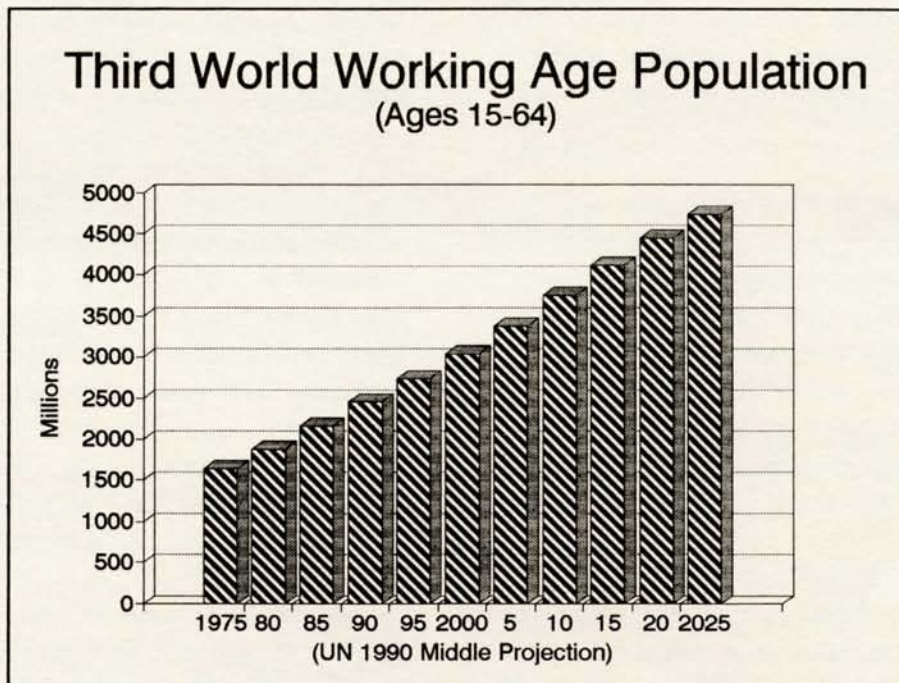
A Question of Identity

We may find ourselves receiving more illegal migration even if we do not welcome it. There is a major flaw in the Immigration Reform and Control Act

of 1986 (IRCA). Various groups, including Congressional commissions, had urged that there be a better process of identifying U.S. citizens and aliens with a right to work here, in order to avoid widespread fraud. As part of the final compromise, that proposal was weakened to nullity, and subsequently there has been a proliferation of fraudulent documentation. If the health program is not to be offered to the whole world, we will need to know who is entitled, and that will

require a much better system of identification than now exists, based perhaps on one's Social Security number and a call-in system such as has been perfected by the credit card companies.

Help seems to be on the way from an unexpected quarter: California. The state is the immigrants' primary destination, and it



is foundering. Governor Wilson (who as a Senator sponsored the biggest loophole in the 1986 act and later voted for the 1990 act increasing legal immigration) has seen the light. He has called for a series of measures to bring illegal immigration under control. With considerable fanfare — he appeared at one news conference surrounded by stacks of forged identity cards — he has asked President Clinton to "use California as a testing ground for a tamper-proof identification card to combat illegal immigration."¹³

In response, President Clinton has said the unutterable: that his administration is studying the feasibility of such a card, and he linked it specifically to the health care proposal, even while remarking that a national identity card "sort of smacks of Big Brotherism."¹⁴

The argument I would make, and that the President apparently understands, is that a better national system of identifying individuals is a necessity if we are to institute a national health program that the nation can afford. There are already powerful arguments for

better identification, such as the protection of wage and labor standards, the identification of terrorists and criminals, and the imperative need to control illegal immigration if we are to regain some degree of control over the nation's demographic future.

The argument against a "a national ID card" is somewhat spurious. We already have a national identity card, the Social Security card, which is used as an identifier for tax purposes, drivers' licenses, and other purposes. We do not control it very well or use it very effectively. The health insurance aspect seems to clinch the argument. We should get on with an improved system.

The Impact on Fertility

A true national health program would constitute a fundamental change of direction, akin to the New Deal. It deserves, not just a close examination of the budgetary implications, but a policy debate integrating it with other broad national questions. Where, for instance, do we want to go, demographically, and how does health care relate to that question?

Migration and fertility are (along with mortality) the two determinants of our demographic future. A priori, one assumes that the completeness of insurance coverage of child-bearing will have some effect on women's decisions whether to have babies. There is very little systematic evidence on the matter. We have made our national policies affecting fertility — tax policy, welfare and health policies, etc. — without considering the demographic impact, just as we have made immigration laws without any thought of the demographic results.

If the nation cares where it is heading, it should look to the connection between our population future and the environmental, social and unemployment problems we face. The debate on the health care package provides an opportunity to consider whether we wish to encourage lower fertility, and to get some expert testimony as to how the two might be connected. We might, for instance, look to the Singapore example and offer maternity benefits only for the first two children.

Lest the reader think I have gone mad, I hasten to admit that opinion in the U.S. is presently very far from any such decision.

It would probably be seen as intolerable governmental interference in private behavior, and by the religious Right as morally intolerable. I would counter that behavior is no longer private when it is publicly financed and results in major and probably undesirable demographic results. If we see ourselves as a modern nation capable of exerting some conscious influence on our future, we should perhaps compare our timidity in this area to Iran, which U.S. opinion would probably select as an excellent example of a backward theocracy. Iran has recently passed legislation to withhold insurance benefits and maternity leave for children after the third.¹⁵

The Changing Nature of Employment

The high costs of health and retirement benefit packages — which now total 25 percent or more of labor costs — have forced employers in the past year to scramble to meet new legal requirements to fund those packages. To minimize the long term costs of hiring full time employees, employers are turning increasingly to part time and temporary help. The trend has been underway for some time but it seems to have accelerated in the current shaky economic recovery.

The President hopes to finance the new health care program in large part from mandatory employer contributions. If he does so, employers will have further reason to turn increasingly to temps and part time help not covered by the benefit package — or they will seek to substitute technology for labor, or plan to move their operations to lower wage countries.

The more that business shifts to temporary and part time help, the larger the portion of the health program that must be funded from the government program — financed presumably by general taxes — intended as a safety net for people without a health program at work. An attempt to force business to absorb the costs will make the alternatives — automation and departure — more attractive. As if it were fated to propose policies with synergistic ill effects, the administration is concurrently pressing for passage of NAFTA (the North American Free Trade Agreement), one purpose of which is to make it easier for American business to move its operations to Mexico.

The nation is headed for an expensive surprise if it

estimates the public costs of the proposed health program on past experience rather than current trends.

Conclusion

The health care decision is going to shape the society, fundamentally, in future years. Because it is so important and has the sort of ramifications described above, it offers both a danger and an opportunity. The danger is that, if we take the decisions without looking at those ramifications, the nation's health bill may put us in even deeper financial trouble, and one by-product — further encouraging population growth — may turn out to be even more important than the health bill itself. The opportunity is the chance to get out of the tunnel in which the nation's important decisions are usually made and to look before we leap to decisions in this fundamental area.



NOTES

1. Joseph Califano, "The Last Time We Reinvented Health Care", *Washington Post*, OpEd page a23, 4-1-93.
2. It is perhaps instructive that other industrial nations with national health plans find themselves moving in the opposite direction from the United States, toward cost containment driven by unemployment and stagnant economies. France, Germany, the United Kingdom, Spain and Italy have been debating or instituting cost control measures. Reuters, Paris, 6-29-93, 10:37am.
3. See Lindsey Grant et al, *Elephants in the Volkswagen* (New York: W.H. Freeman & Co., 1992), Chapter 12 "Too Many Old People?".
4. Annual figures from *Statistical Abstract of the U.S., 1992*, Table 192. An unknown part of the growth resulted from improved reporting. Other data through March 31, 1993, by telephone May 28, 1993 from HHS Centers for Disease Control, Atlanta.
5. Centers for Disease Control (CDC), Atlanta, quoted in Boyce Rensburger, "AIDS Spreads Fastest Among Young Women...", *Washington Post*, 7-28-93.
6. United Nations, *World Population Prospects: the 1992 Revision*, Chapter III. The countries are Malawi, Rwanda, Uganda and Zambia. One cannot even draw from this catastrophe the bitter hope that AIDS may slow Africa's population growth rate. Not yet. The UN projects that, as a result of the epidemic, the annual population growth of the fifteen most affected nations (all in Africa), from 1995-2000 will be 2.96 percent rather than 3.26 percent. At 2.96 percent, it still takes just 24 years for populations to double. Expect more trouble.
7. Karen Hein, director of the adolescent AIDS program, Montefiore Medical Center, to the Ninth International Conference on AIDS, quoted by Cynthia Johnson, "Teenagers Seen Leading Next Wave of AIDS Epidemic", Reuters, Berlin, 6-5-93.
8. Daniel E. Koshland, Jr., "The Microbial Wars", Editorial, *Science*, 8-21-92, p.1021.
9. U.S. Department of State, *The Global AIDS Disaster: Implications for the 1990s* (Department of State Publication 9955, July 1992.) In sub-Saharan Africa, the incidence of HIV infection is expected to quadruple to 48 million by 2000.
10. The proposal came from Shenyang, in the Northeast, and was cited approvingly by the official New China News Agency. Reuters, Beijing, 7-31-93, 07:41.
11. The Census Bureau 1993 middle projection for 2050 is 392 million. A new projection by demographer Leon Bouvier yields 397 million by 2050. (Leon Bouvier & Lindsey Grant, *How Many Americans? Immigration, Population and the Environment*. San Francisco: Sierra Club Books, publication scheduled August 1994.) Both are based on current fertility and immigration patterns.
12. Associated Press, Washington, 8-23-93, 10:52.
13. Reuters, Los Angeles, 8-9-93, 18:55 and United Press (UP), 9-3-93, 16:40.
14. Reuters, Los Angeles, 8-13-93, 14:21.
15. Reuters, Nicosia, 6-3-93, 10:48 am.



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