Month 6: The War on Poverty - Who Benefited and Who Was Left Behind?

In January 1964, President Lyndon B. Johnson declared an "unconditional war on poverty" in his State of the Union Address, framing poverty as not only an economic challenge but also a moral one. The subsequent rollout of Great Society Programs represented one of the most ambitious attempts in American history to reduce poverty and expand opportunity. These initiatives touched nearly every part of social life—healthcare, education, urban and rural development—and continue to influence policy today. Yet the War on Poverty raises a persistent question: who truly benefited, and who was left behind? This paper examines the impact of the Great Society across two key areas: healthcare access through Medicaid and early education through Head Start. While these programs transformed the lives of millions, gaps in implementation and long-term outcomes reveal the uneven legacy of Johnson's vision.

The expansion of Medicaid and the ongoing gaps in healthcare access

Medicaid was established through the Social Security Act of 1965 as part of the Great Society, with the intention of providing health coverage to low-income and vulnerable populations. Over time, its expansion, especially under the Affordable Care Act (ACA), further extended coverage. Yet gaps remain in access, enrollment, and outcomes. According to a KFF report, by 2024, 44 million people were enrolled in ACA-related coverage, including 21.3 million who gained coverage through Medicaid expansion. States that expanded Medicaid saw significant improvements in insurance coverage, access to regular sources of care, and fewer delays in treatment due to cost. Recent studies have also shown measurable health impacts, estimating that Medicaid expansions saved tens of thousands of lives between 2010 and 2022, reducing mortality risk by approximately 2.5% overall among those who gained coverage.

In the states that have not adopted Medicaid expansion under the ACA, among them Texas, Tennessee, Georgia, South Carolina and Florida, roughly 1.5 million adults remain uninsured despite having incomes that fall below the poverty line, reinforcing the coverage gap. This is due to ineligibility under state rules, which disqualify individuals from both Medicaid and subsidies in the health insurance marketplaces. Rural residents face additional barriers even when eligible, as they are less likely to take up Medicaid or other coverage, have access to fewer healthcare providers, longer travel distances, and lower awareness. A 2025 study found that rural residents had lower enrollment than their urban counterparts, and that the gap widened in some respects

after ACA implementation. Furthermore, paperwork errors, redetermination, or difficulty navigating systems lead to loss of coverage despite meeting the criteria.

Beyond structural issues, there are broader limitations that Medicaid expansion alone cannot fix. Medicaid is expensive, requiring states to match federal funds to some degree, which creates political and budgetary pressures that fuel opposition to expansion. Recently, the GOP has targeted a Medicaid loophole, where states are allowed to tax hospitals and nursing homes in order to draw down more federal matching funds, arguing this distorts the program's intent. Additionally, provider participation remains uneven, particularly in rural or low-income areas, as some physicians are unwilling to accept Medicaid patients due to low reimbursement rates. This creates a disconnect where insurance coverage does not always translate into actual access to care.

In 2025, policies under President Trump have further complicated these challenges. The administration's One Big Beautiful Bill Act introduced new work requirements for Medicaid recipients ages 19-64, mandating 80 hours per month of work, volunteering, or school to keep coverage. Experts warn that this will disproportionately affect rural residents, caregivers, and those with unstable employment. Further, it authorizes states to impose new fees, shortens retroactive Medicaid payments from three months to one, and restricts provider payment flexibility, which may reduce provider participation and raise costs for low-income patients. These changes could increase the uninsured population by 50% over the next decade, reversing much of the progress achieved under the ACA.

Head Start and early education programs: successes and limitations

Head Start was established through the Economic Opportunity Act of 1964 to promote school readiness for children from low-income families, providing early childhood education, health, nutrition, and parent involvement. Today, it remains a central early childhood program.

In fiscal year 2024, Head Start served roughly 730,751families. Among them, 38% identified as Hispanic/Latino and 29% as Black/African American. About 55,000 families experienced homelessness, and about 23% of those found housing during the program year. The program provides not just preschool education but health screenings, meals, services for parents, including job training and adult education to approximately 84,000 families. Long-run studies show that participation in Head Start increases educational attainment. One analysis found, using data from its rollout between 1965 and 1980, Head Start enrollment was associated with 0.65 year more schooling, a 2.7% increase in high school completion, 8.5% higher college enrollment, and a 39% increase in college graduation.

Unfortunately, more recent cohort studies highlighted that for some children, when followed into adulthood, the gains in outcomes such as earnings, behavior, or school achievement tend to fade. Such is called the "fade-out effect." For example, a replication across cohorts using the CNLSY data found generally null impacts on some school-age and early adult outcomes in more recent

cohorts. Additionally, some children enter Head Start with non-educational barriers, such as health, nutrition, homelessness, instability, and trauma that the program can't fully remediate. Early education helps, but upstream issues continue to weigh heavily.

Recent Trump administration proposals and regulatory changes are further straining Head Start and early education programs, deepening the problems rather than solving them. Earlier this year, the draft of the budget was ready to eliminate virtually all funding for Head Start, cutting off funding for health screenings, meals, and developmental support for hundreds of thousands of children. However, the president's final proposal kept it at the same funding level. Simultaneously, the administration has closed several regional HHS offices and laid off staff who manage Head Start grants, which has led to delays in funding disbursement and even temporary closures of some centers. These steps disproportionately burden those who already struggle with the fade-out effect, accessibility, instability, and non-educational barriers in early childhood.

Policy Recommendations

To ensure that Medicaid and Head Start continue delivering value to both taxpayers and families, nationwide Medicaid expansion with flexible state incentives should be mandated to help close the coverage gap for 1.5 million adults while strengthening state economies. This would lower uncompensated hospital care, stabilize rural hospitals, and reduce costly emergency room visits. These changes ultimately reduce state and federal spending on avoidable care, while keeping more working-age adults healthy and in the labor force. Second, simplifying enrollment and redetermination processes would reduce bureaucratic waste. Adopting an automated verification system saves staff time, prevents eligible enrollees from losing coverage due to paperwork errors, and makes the government more efficient.

For Head Start, maintaining and strengthening the program is an investment in the future workforce. Head Start's goal is to promote school readiness, which translates to higher graduation and employment rates among participants and directly decreases the rate of future dependence on public assistance. Increasing funding for trauma-informed care, housing stability, and family services would improve program outcomes while lowering spending on remedial education, healthcare, and social services. These returns highlight why policymakers should protect Head Start grants at all costs.

A bipartisan commitment to funding stability, paired with accountability measures, would align with the administration's goals of reducing waste and ensuring federal programs deliver measurable results.

Conclusion

The War on Poverty demonstrated that bold federal action can reshape opportunity, and programs like Medicaid and Head Start. Continued gaps in healthcare access, rural inequities, and administrative barriers have undermined Medicaid and Head Start. The Trump administration's 2025 policies imposing Medicaid work requirements, limiting payment flexibility, and disrupting

Head Start oversight risk deepening these divides and reversing progress. To move forward, policymakers must expand Medicaid universally, raise provider reimbursement, and strengthen rural health infrastructure, while also streamlining enrollment to prevent coverage loss. They must also improve Head Start by renewing investment in trauma-informed care, housing stability, and workforce support, which is essential to address persistent inequities and sustain long-term gains. Only by combining coverage with access, and education with comprehensive support, can Johnson's vision of an America where poverty is not simply managed, but meaningfully reduced, be upheld.