PAYING MORE, GETTING LESS

BY JOEL A. HARRISON

How much is the sick U.S. health care system costing *you*?

By any measure, the United States spends an enormous amount of money on health care. Here are a few of those measures. Last year, U.S. health care spending exceeded 16% of the nation's GDP. To put U.S. spending into perspective: the United States spent 15.3% of GDP on health care in 2004, while Canada spent 9.9%, France 10.7%, Germany 10.9%, Sweden 9.1%, and the United Kingdom 8.7%. Or consider per capita spending: the United States spent $6,037 per person in 2004, compared to Canada at $3,161, France at $3,191, Germany at $3,169, and the U.K. at $2,560.

By now the high overall cost of health care in the United States is broadly recognized. And many Americans are acutely aware of how much they pay for their own care. Those without health insurance face sky-high doctor and hospital bills and ever more aggressive collection tactics—when they receive care at all. Those who are fortunate enough to have insurance experience steep annual premium hikes along with rising deductibles and co-pays, and, all too often, a well-founded fear of losing their coverage should they lose a job or have a serious illness in the family.

Still, Americans may well *underestimate* the degree to which they subsidize the current U.S. health care system out of their own pockets. And almost no one recognizes that even people without health insurance pay substantial sums into the system today. If more people understood the full size of the health care bill that they as individuals are already paying—and for a system that provides seriously inadequate care to millions of Americans—then the corporate opponents of a universal single-payer system might find it far more difficult to frighten the public about the costs of that system. In other words, to recognize the advantages of a single-payer system, we have to understand how the United States funds health care and health research and how much it actually costs us today.

PAYING THROUGH THE TAXMAN

The U.S. health care system is typically characterized as a largely private-sector system, so it may come as a surprise that more than 60% of the $2 trillion annual U.S. health care bill is paid through taxes, according to a 2002 analysis published in *Health Affairs* by Harvard Medical School associate professors Steffie Woolhandler and David Himmelstein. Tax dollars pay for Medicare and Medicaid, for the Veterans Administration and the Indian Health Service. Tax dollars pay for health coverage for federal, state, and municipal government employees and their families, as well as for many employees of private companies working on government contracts. Less visible but no less important, the tax deduction for employer-paid health insurance, along with other

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health care-related tax deductions, also represents a form of government spending on health care. It makes little difference whether the government gives taxpayers (or their employers) a deduction for their health care spending, on the one hand, or collects their taxes then pays for their health care, either directly or via a voucher, on the other. Moreover, tax dollars also pay for critical elements of the health care system apart from direct care—Medicare funds much of the expensive equipment hospitals use, for instance, along with all medical residencies.

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All told, then, tax dollars already pay for at least $1.2 trillion in annual U.S. health care expenses. Since federal, state, and local governments collect about $3.48 trillion annually in taxes of all kinds—income, sales, property, corporate—that means that *more than one third (34.4%)* of the aggregate tax revenues collected in the United States go to pay for health care.

Beyond their direct payments to health care providers and health insurance companies, then, Americans already make a sizeable annual payment into the health care system via taxes. How much does a typical household contribute to the country's health care system altogether? Of course, households pay varying amounts in taxes depending on income and many other factors. Moreover, some households have no health insurance coverage; others do have coverage for which they may pay some or all of the premium cost. What I aim to do here is to estimate the average size of the health care cost burden for households at different income levels, both those with job-based health coverage and those with no coverage.

Note that the estimates in the table (right) *do not include* out-of-pocket expenses. For those with health insurance, these include copays, deductibles, and uncovered expenses (consider, for example, that even my high-end policy does not cover commonly used home medical equipment such as oxygen). For those without insurance, of course, out-of-pocket expenses include their full hospital, doctor, and pharmacy bills.

The first row ("Share and Amount of Income Going to Health Care via Taxes Alone") shows how much of the total tax burden on households at three income levels goes into the nation's health care system. In other words, a family with an annual income of $50,000 that has no health insurance nonetheless contributes nearly 10% of its income to health care merely by paying typical income, payroll, sales, excise, and other taxes. A person who earns about $25,000 a year and has no health coverage already contributes over $2,400 a year to the system—enough for a healthy young adult to purchase a year's worth of health insurance.

The next two rows add in, for individuals and for families, the cost of employer-based health insurance. So, a household at the $50,000 income level with family health insurance coverage is paying *over a quarter* of its income into the health care system.

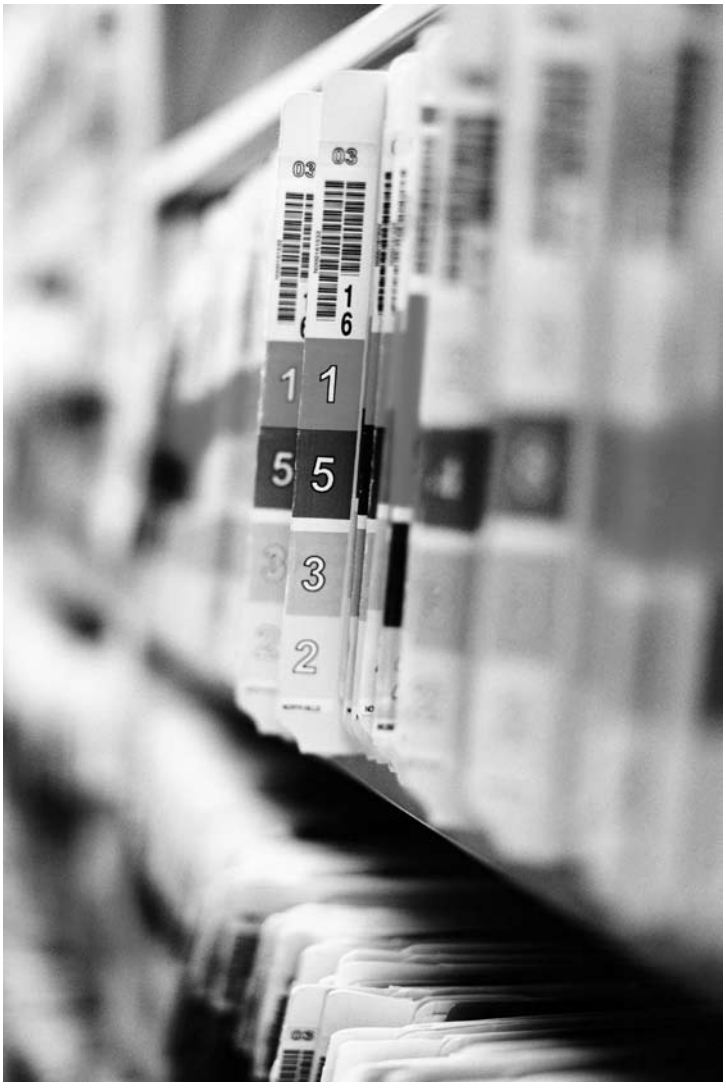
How were these figures derived? The tax component of the figures represents 34.4% of the total tax burden (federal, state, and local) on households at the three income levels. Of course, estimating average combined federal, state, and local taxes paid by households at different income levels is not a simple matter. The most comprehensive such estimates come from the Tax Foundation, a conservative think tank. Other analysts, however, including the liberal Center on Budget and Policy Priorities, view the Tax Foundation's figures as overestimating the total tax burden. The center has published its own estimates, based on figures from the Congressional Budget Office and Congress's Joint Committee on Taxation. The figures in the table are based on the CBO's numbers, which fall in between the Tax Foundation's esti-

What Americans Pay into the U.S. Health Care System Today		Household Income Level		
		$25,000	$50,000	$75,000
Share and Amount of Income Going to Health Care via Taxes Alone		9.0% ($2,425)	9.8% ($5,300)	10.7% ($8,633)
Share and Amount of Total Wage Packet Going to Health Care for Households with Insurance	Individual	22.0% ($6,904)	16.8% ($9,779)	15.4% ($13,112)
	Family	37.2% ($14,531)	26.4% ($17,406)	22.3% ($20,749)

Note: The share of total wage packet going to health care was calculated as follows:

$$\frac{\text{(amount of total tax burden going to health + annual health insurance premium)}}{\text{(annual salary + payroll tax [FICA and Medicare] + annual health insurance premium)}}$$

Further details of the calculations are available at www.dollarsandsense.org.



mates and the JCT-based estimates. (Estimates based on the Tax Foundation and JCT figures, along with details of the analysis, can be found at www.dollarsandsense.org.) It is worth noting that using the Tax Foundation's numbers, which show a larger share of income going to taxes at every income level, would have made the story even worse. For a family with health insurance earning $50,000 a year, for instance, the share of income going into health care would have been 28.7% rather than 26.4%.

For insurance premiums: in 2007, the average annual premiums for health insurance policies offered through employers were $4,479 for individuals and $12,106 for families, according to the Kaiser Family Foundation's annual survey of health benefits. Of course, some employers pay all or a large share of that premium while others pay half or less, leaving much of the premium cost to the worker. Either way, however, the full premium cost represents a bite taken out of the worker's total "wage packet"—the cost of wages plus benefits. This becomes evident when premiums go up: workers either see their own premium payments rise directly, or else face cuts or stagnation in their wages and non-health benefits. For that reason, economists typically view the entire premium as a cost imposed on the worker regardless of variations in employer contribution.

These figures are not meant to be exact, but do offer reasonable estimates of how much U.S. families are actually paying into the country's health care system today. Again, they do not include out-of-pocket expenses, which averaged 13.2% of all health care expenditures in 2005. Moreover, they do not include the risk of bankruptcy that health care costs impose: 50% of consumer bankruptcies in the United States stem from medical bills, including a surprising number among households that do have some kind of health coverage. Nor do they include the approximately 20% of auto

MORE TAXPAYER DOLLARS, LESS MEDICAL RESEARCH

The United States accounts for 51% of all global spending on medical research, according to a 2006 Global Forum for Health Research report. The report estimated that 60% of this is public funding, 8% comes from nonprofit institutions, and only 32% comes from the private sector. Even more important, most basic research—the research that undergirds most applied research and that requires long-term investment before any payoff can be expected—is heavily funded by the public.

That the United States spends the most money, however, does not necessarily mean that this country does the most research. U.S. heart surgeons charge twice as much as Canadian heart surgeons—or more—for the same coronary bypass operation, with no difference in morbidity or mortality. Likewise, U.S. taxpayers pay more for the same research. It isn't how much you pay, but how much quality research is carried out. When I lived in Canada and in Sweden, if I applied for a research grant for, say, $200,000, an additional circa 15% would be tacked on to cover administration of the grant and other so-called indirect costs. In the United States, the indirect-cost "surcharge" on a research grant to a university can range from about 50% at public universities up to 100% at private universities. Whereas in Canada and Sweden, libraries, computer centers, offices for grad students, and so on are included in university budgets, in the United States much of the funding for these basic facilities is drawn from the "overhead" line added on to grants. So, the same $200,000 research project would cost about $230,000 in Sweden or Canada, versus $300,000 to $400,000 in the United States.

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insurance premiums or the 40% of workers' compensation premiums that pay for medical expenses.

WHERE DOES ALL THE MONEY GO?

After you've finished gasping in surprise at the share of your income that is already going into health care, you may wonder where all that money goes. One answer is that the United States has the most bureaucratic health care system in the world, including over 1,500 different companies, each offering multiple plans, each with its own marketing program and enrollment procedures, its own paperwork and policies, its CEO salaries, sales commissions, and other non-clinical costs—and, of course, if it is a for-profit company, its profits. Compared to the overhead costs of the single-payer approach, this fragmented system takes almost 25 cents more out of every health care dollar for expenses other than actually providing care.

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Of the additional overhead in the current U.S. system, approximately half is borne by doctors' offices and hospitals, which are forced to maintain large billing and negotiating staffs to deal with all the plans. By contrast, under Canada's single-payer system (which is run by the provinces, not by the federal government), each medical specialty organization negotiates once a year with the nonprofit payer for each province to set fees, and doctors and hospitals need only bill that one payer.

Of course, the United States already has a universal, single-payer health care program: Medicare. Medicare, which serves the elderly and people with disabilities, operates with overhead costs equal to just 3% of total expenditures, compared to 15% to 25% overhead in private health programs. Since Medicare collects its revenue through the IRS, there is no need to collect from individuals, groups, or businesses. Some complexity remains—after all, Medicare must exist in the fragmented world that is American health care—but no matter how creative the opponents of single-payer get, there is no way they can show convincingly how the administrative costs of a single-payer system could come close to the current level.

Some opponents use current U.S. government expenditures for Medicare and Medicaid to arrive at frightening cost estimates for a universal single-payer health care system. They may use Medicare's $8,568 per person, or $34,272 for a family of four (2006). But they fail to mention that Medicare covers a very atypical, high-cost slice of the U.S. population: senior citizens, regardless of pre-existing conditions, and people with disabilities, including diagnoses such as AIDS and end-stage renal disease. Or they use Medicaid costs—forgetting to mention that half of Medicaid dollars pay for nursing homes, while the other half of Medicaid provides basic health care coverage, primarily to children in low-income households, at a cost of only about $1,500 a year per child.

GETTING WHAT WE'VE ALREADY PAID FOR

Americans spend more than anyone else in the world on health care. Each health insurer adds its bureaucracy, profits, high corporate salaries, advertising, and sales commissions to the actual cost of providing care. Not only is this money lost to health care, but it pays for a system that often makes it more difficult and complicated to receive the care we've already paid for. Shareholders are the primary clients of for-profit insurance companies, not patients.

Moreover, households' actual costs as a percentage of their incomes are far higher today than most imagine. Even families with no health insurance contribute substantially to our health care system through taxes. Recognizing the hidden costs that U.S. households pay for health care today makes it far easier to see how a universal single-payer system—with all of its obvious advantages—can cost most Americans less than the one we have today. ■

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I met him at a Summer Job, when I went to SDSU.

SOURCES Center on Budget and Policy Priorities, "The Debate Over Tax Levels: How Much Does a Typical Family Pay?" March 11, 1998; Center on Budget and Policy Priorities, "Tax Foundation Figures Do Not Represent Middle-Income Tax Burdens: Figures May Mislead Policymakers, Journalists, and the Public," April 13, 2006; Center on Budget and Policy Priorities, "Clearing Up Confusion on the Cost of Covering Uninsured Children Eligible for Medicaid or SCHIP," March 13, 2007; Gary Claxton et al., "Health Benefits in 2007: Premium Increases Fall to an Eight-Year Low, While Offer Rates and Enrollment Remain Stable," *Health Affairs* 26(5), 2007 [based on "Employer Health Benefits 2007 Annual Survey" by the Kaiser Family Foundation]; Congressional Research Service, "U.S. Health Care Spending: Comparison with Other OECD Countries," September 17, 2007; Andrés de Francisco and Stephen Matlin, eds., *Monitoring Financial Flows for Health Research 2006* (Global Forum for Health Research, 2006); Tax Foundation, "Who Pays America's Tax Burden, and Who Gets the Most Government Spending?" March 2007; Public Citizen Congress Watch, "Rx R&D Myths: The Case Against the Drug Industry's R&D 'Scare Card'," July 2001; Steffie Woolhandler et al., "Health Care Administration in the United States and Canada: Micromanagement, Macro Costs," *Int'l Journal of Health Services* 34(1), 2004; Steffie Woolhandler and David Himmelstein, "Paying for National Health Insurance—And Not Getting It," *Health Affairs* 21(4), July/August 2002.

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