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## Who really pays for health care?

By Ezekiel J. Emanuel and Victor R. Fuchs

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Who really pays for health care in the United States?

Americans believe employers pay the bulk of workers' premiums, government pays for Medicare, Medicaid and the State Children's Health Insurance Program and individuals pay some premiums as well as deductibles and co-pays. This is wrong. Business, government and individuals do not share the financial responsibility for health coverage. Individuals bear the full cost of health care through lower wages and taxes.

Employers like to say—and often believe—that *they* pay for health care. They complain that the huge increases in health-care costs are coming out of their bottom lines—as if costs come out of profits. Union leaders also like to have their members think that health benefits are a bonus on top of wages and that the leadership is negotiating hard to get them the free benefit.

Employers sponsor health insurance for the majority of Americans, but that is not the same as employers bearing the cost for workers' health insurance. Wages and fringe benefits, such as health insurance, are simply components of overall worker compensation. When employers provide health insurance to workers, they may define the benefits, select the health plan to manage the benefits and collect the funds to pay the health plan, but they do not bear the ultimate cost. What is labeled as employers' contribution to the health-insurance premium is really paid for by employees through lower wages and take-home pay.

## Looking at the facts

This cost-wage trade-off is usually well hidden from employers and workers, but many studies show that it is a painful reality for average Americans. For instance, over the last 30 years, health-insurance premiums have increased by 300 percent after adjustment for inflation. During that time, after-tax corporate profits per employee have increased 200 percent, while workers' average hourly earnings, adjusted for inflation, decreased by 4 percent. Rather than coming out of corporate profits, the increasing cost of health care has resulted in relatively flat wages for 30 years.

To illustrate, consider Wal-Mart Stores Inc. and Safeway Inc. Wal-Mart, a non-unionized retail giant, is notorious for skimpy health benefits. From 2004 through 2006, its after-tax profits averaged 1.9 percent of sales. Safeway, a highly unionized supermarket chain, offers generous health benefits that cost more than 2 percent of sales. But in 2004 through 2006, its after-tax profits averaged 1.8 percent of sales, virtually the same as Wal-Mart. The difference between Wal-Mart and Safeway in the provision of health benefits is not found in the companies' profits.

Another way to see this is to compare the change in workers' wages with the change in health-care costs. Why were the mid-1990s such good economic times for average Americans? Between 1994 and 1999, the growth in health-care costs was low and therefore wages went up. But from 1988 to 1991 and 2001 to 2004, health-care costs went up rapidly, sending wages down.

What about Medicare, Medicaid and SCHIP? The government's funds for health care don't come from governors, senators, representatives or the president. When government pays for increases in health-care costs, it taxes current citizens, borrows—asking future taxpayers to foot the bill—or reduces other state services that benefit citizens. Health-care costs are now the single largest state expenditure, exceeding even education. Recently, as costs for Medicaid and other government health-care programs have increased faster than tax receipts, states have resorted to cutting the funds for education, forcing the substantial recent rise in tuition and fees for state colleges. Middle-class families, falling victim to rising health-care costs, are finding it harder to pay for their children's education.

## Time to get serious

So, what does the trade-off mean?

First, Americans need to forget about the myth of a free lunch. Workers are not getting something from employers while paying nothing. They are paying for their health insurance, including the premiums supposedly contributed by their employers.

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Second, to help the struggling middle class, we need to get health-care costs under control. There is no way to have a sustained rise in middle-class incomes without restraining the growth in health-care expenditures. Similarly, if we want government to invest in better primary education and more affordable colleges we need to find a way to hold down the cost of health care. We are robbing our children to pay for medicine.

We need to rewrite the social contract in America. We need to get employers out of providing health insurance. It is one of the most inefficient ways to get people covered, and it impedes efforts to keep costs down.

Instead, we need to provide all Americans with a standard benefits package regardless of their income, employment status, health status or age. This will provide Americans invaluable peace of mind, defuse labor-management conflict and get people to focus on value and determining whether more health care is worth the added costs.

## Keeping costs sane

How do we get health-care costs under control? We need to eliminate the overuse of medical tests and treatments. For instance, studies have shown that doctors perform more than twice as many Caesarean sections in Miami and Fresno, Calif., as in Minneapolis, even after taking into account the differences among patients—with no improvement in the health of mothers or babies. Similarly, many studies show that more hospitalizations, use of specialists and frequent tests do not lead to improved survival rates or quality of life—just much higher costs. Further we need to use cost-effective medical care when there are options. This is obvious for prescribing generic drugs rather than similar brand-name drugs, but it is also true for tests and treatments. Most important, patients with chronic conditions such as diabetes, heart failure and emphysema account for 70 percent of health-care costs. We need more coordinated care with fewer specialists involved to keep these patients taking their medications, adhering to their diets and

other treatments, and staying

out of hospitals where costs are high.

Achieving these changes will not be easy, but three policy changes will set the necessary foundation. First, an Institute for Technology and Outcomes Assessment is critical to collecting information comparing the effectiveness and costs of different medical interventions. That data will allow doctors to choose the most effective treatments. Second, we need a crash program to institute electronic medical records. Today, only 15 percent of doctors and 25 percent of hospitals have computerized records. The government has to provide financial incentives and mandate that within five years all doctors and hospitals have interoperable electronic medical records.

Finally, we need to change how we pay doctors and hospitals. Most doctors are paid fee-for-services, that is they get money for doing more tests and procedures and not for coordinating care and ensuring high quality medical care. Doctors need to be paid on the basis of performance and patient outcomes.

Controlling health-care costs is not easy, but for average Americans it is the only way to sustainably increase wages. And if we do it right, it will actually improve the quality of health care.

*Dr. Ezekiel J. Emanuel is chair of the department of bioethics at The Clinical Center of the National Institutes of Health. Victor R. Fuchs is a professor of economics (emeritus) at Stanford University.*

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