A Primer for Social Security Reform
Appendix: Universal Health Insurance

Our simple heath insurance model provides an exceedingly simple Universal Health Insurance (UHI) model consisting of a government agency, which pays bills submitted by providers of covered medical services, is funded, via payroll taxes, by tax for each person equal to the annual total amount paid out plus overhead divided by the number of people paying the tax, with subsidies for low income persons and their dependents, paid for by a tax on all income. Various fine-tuning comes to mind; for example, in calculating the payroll tax the breadwinners must pay, base it on average expenditures for each family members age group or make families the basic unit. This formulation at least brings up front that there is no free lunch.

The big problem is the alarmingly large increases in annual U.S. health care expenditures, which experts have amply demonstrated are due to the creation of new, effective expensive medical service produced by discoveries from scientific medical research. A secondary cause is alarmingly high overhead costs. So far there is no sign that the public is willing to forgo using new and very expensive medical services. There is a notion that the introduction of the marketplace mechanism can help but at the consumer level it can only play a minor role inasmuch as on the demand side, medical care is a top priority limited only by the ability to pay, that is, up to what one can beg barrow or steal. At present supply-and-demand does play a role, the suppliers being a great number of HMO's and health insurance companies, and the buyers, employers providing their employees with health insurance. Unfortunately this method of control is at an extraordinarily high overhead cost, largely overcoming its cost reduction effects. This arrangement also controls Medicare costs, which has a very low overhead rate but controls costs by payments for medial services based on the going rates established in the under 65 age group.

With respect to UHI, we are 50% there (or perhaps 40%) in that it is generally agreed that everyone should have access to good medical care. We are creeping toward the obvious corollary that everyone must pay, mitigated by the ability to pay, controlling costs being the big obstacle. In Canada and the U.K. cost are controlled by a government agency setting a total budget for the year and fees for services, the down side being long waiting times for some services, longer, but of the same order of magnitude, as in the U.S. France with almost no waiting lines uses an interesting combination of techniques. You pay for all medical services you receive and are reimbursed by the government's social services agency, refunding between 0% and 100% depending on the type of medical care, on average about 70%; for low-income people it is 100%. Fees for services are specified with some doctors charging more, with patients making up the difference out of pocket or from insurance. Insurance covering your expenses, priced at about one $60 a month, is available from mutual insurance companies. The cost of your mutual insurance is unaffected by your health, lifestyle or number of previous claims. In fact, they are not even allowed to ask medical questions.

WHO's "World Health Report" ranked France number 1, U.S. 37. Italy ranked 2, Spain 7, Austria 9, Japan 10, UK 18, Sweden 23, Germany 25, and Canada 30. The U.S. comes in number one in ranking by cost, 50% higher than number 2. There is a popular notion in the U.S. that although our system is expense it is the best

in the world, at least for the well off, not withstanding the absence of evidence supporting this claim. A sensible first step would be a detailed comparison of the costs of medical services in the U.S. and other countries. Precisely, in the U.S., where does the $40,000 for a hip replacement go, as compared to $10,000 in England.

According to health care economists, the U.S.'s $ trillion a year health care industry's influence on the public, and more so on Congress, makes changing to UHI entirely impossible. Perhaps it would be feasible for the U.S. to gradually move to UHI, starting with covering all reasonably routine medical services as a matter of public health. Add outsourcing and one is probably home with much improved health services or, perhaps in stages, as experience is gained, add all medical services of proven efficacy and on from there to adding plausible services whose efficacy is under investigation
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