

THE MORAL-HAZARD MYTH

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The bad idea behind our failed health-care system.

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Tooth decay begins, typically, when debris becomes trapped between the teeth and along the ridges and in the grooves of the molars. The food rots. It becomes colonized with bacteria. The bacteria feeds off sugars in the mouth and forms an acid that begins to eat away at the enamel of the teeth. Slowly, the bacteria works its way through to the dentin, the inner structure, and from there the cavity begins to blossom three-dimensionally, spreading inward and sideways. When the decay reaches the pulp tissue, the blood vessels, and the nerves that serve the tooth, the pain starts—an insistent throbbing. The tooth turns brown. It begins to lose its hard structure, to the point where a dentist can reach into a cavity with a hand instrument and scoop out the decay. At the base of the tooth, the bacteria mineralizes into tartar, which begins to irritate the gums. They become puffy and bright red and start to recede, leaving more and more of the tooth's root exposed. When the infection works its way down to the bone, the structure holding the tooth in begins to collapse altogether.

Several years ago, two Harvard researchers, Susan Starr Sered and Rushika Fernandopulle, set out to interview people without health-care coverage for a book they were writing, "Uninsured in America." They talked to as many kinds of people as they could find, collecting stories of untreated depression and struggling single mothers and chronically injured laborers—and the most common complaint they heard was about teeth. Gina, a hairdresser in Idaho, whose husband worked as a freight manager at a chain store, had "a peculiar mannerism of keeping her mouth closed even when speaking." It turned out that she hadn't been able to afford dental care for three years, and one of her front teeth was rotting. Daniel, a construction worker, pulled out his bad teeth with pliers. Then, there was Loretta, who worked nights at a university research center in Mississippi, and was missing most of her teeth. "They'll break off after a while, and then you just grab a hold of them, and they work their way out," she explained to Sered and Fernandopulle. "It hurts so bad, because the tooth aches. Then it's a relief just to get it out of there. The hole closes up itself anyway. So it's so much better."

People without health insurance have bad teeth because, if you're paying for everything out of your own pocket, going to the dentist for a checkup seems like a luxury. It isn't, of course. The loss of teeth makes eating fresh fruits and vegetables difficult, and a diet heavy in soft, processed foods exacerbates more serious health problems, like diabetes. The pain of tooth decay leads many people to use alcohol as a salve. And those struggling to get ahead in the job market quickly find that the unsightliness of bad teeth, and the self-consciousness that results, can become a major barrier. If your teeth are bad, you're not going to get a job as a receptionist, say, or a cashier. You're going to be put in the back somewhere, far from the public eye. What Loretta, Gina, and Daniel understand, the two authors tell us, is that bad teeth have come to be seen as a marker of "poor parenting, low educational achievement and slow or faulty intellectual development." They are an outward marker of caste. "Almost every time we asked interviewees what their first priority would be if the president established universal health coverage tomorrow," Sered and Fernandopulle write, "the immediate answer was 'my teeth.' "

The U. S. health-care system, according to "Uninsured in America," has created a group of people who increasingly look different from others and suffer in ways that others do not. The leading cause of personal bankruptcy in the United States is unpaid medical bills. Half of the uninsured owe money to hospitals, and a third are being pursued by collection agencies. Children without health insurance are less likely to receive medical attention for serious injuries, for recurrent ear infections, or for asthma. Lung-cancer patients

without insurance are less likely to receive surgery, chemotherapy, or radiation treatment. Heart-attack victims without health insurance are less likely to receive angioplasty. People with pneumonia who don't have health insurance are less likely to receive X rays or consultations. The death rate in any given year for someone without health insurance is twenty-five per cent higher than for someone with insurance. Because the uninsured are sicker than the rest of us, they can't get better jobs, and because they can't get better jobs they can't afford health insurance, and because they can't afford health insurance they get even sicker. John, the manager of a bar in Idaho, tells Sered and Fernandopulle that as a result of various workplace injuries over the years he takes eight ibuprofen, waits two hours, then takes eight more—and tries to cadge as much prescription pain medication as he can from friends. “There are times when I should've gone to the doctor, but I couldn't afford to go because I don't have insurance,” he says. “Like when my back messed up, I should've gone. If I had insurance, I would've went, because I know I could get treatment, but when you can't afford it you don't go. Because the harder the hole you get into in terms of bills, then you'll never get out. So you just say, 'I can deal with the pain.' ”

One of the great mysteries of political life in the United States is why Americans are so devoted to their health-care system. Six times in the past century—during the First World War, during the Depression, during the Truman and Johnson Administrations, in the Senate in the nineteen-seventies, and during the Clinton years—efforts have been made to introduce some kind of universal health insurance, and each time the efforts have been rejected. Instead, the United States has opted for a makeshift system of increasing complexity and dysfunction. Americans spend \$5,267 per capita on health care every year, almost two and half times the industrialized world's median of \$2,193; the extra spending comes to hundreds of billions of dollars a year. What does that extra spending buy us? Americans have fewer doctors per capita than most Western countries. We go to the doctor less than people in other Western countries. We get admitted to the hospital less frequently than people in other Western countries. We are less satisfied with our health care than our counterparts in other countries. American life expectancy is lower than the Western average. Childhood-immunization rates in the United States are lower than average. Infant-mortality rates are in the nineteenth percentile of industrialized nations. Doctors here perform more high-end medical procedures, such as coronary angioplasties, than in other countries, but most of the wealthier Western countries have more CT scanners than the United States does, and Switzerland, Japan, Austria, and Finland all have more MRI machines per capita. Nor is our system more efficient. The United States spends more than a thousand dollars per capita per year—or close to four hundred billion dollars—on health-care-related paperwork and administration, whereas Canada, for example, spends only about three hundred dollars per capita. And, of course, every other country in the industrialized world insures all its citizens; despite those extra hundreds of billions of dollars we spend each year, we leave forty-five million people without any insurance. A country that displays an almost ruthless commitment to efficiency and performance in every aspect of its economy—a country that switched to Japanese cars the moment they were more reliable, and to Chinese T-shirts the moment they were five cents cheaper—has loyally stuck with a health-care system that leaves its citizenry pulling out their teeth with pliers.

America's health-care mess is, in part, simply an accident of history. The fact that there have been six attempts at universal health coverage in the last century suggests that there has long been support for the idea. But politics has always got in the way. In both Europe and the United States, for example, the push for health insurance was led, in large part, by organized labor. But in Europe the unions worked through the political system, fighting for coverage for all citizens. From the start, health insurance in Europe was public and universal, and that created powerful political support for any attempt to expand benefits. In the United States, by contrast, the unions worked through the collective-bargaining system and, as a result, could win health benefits only for their own members. Health insurance here has always been private and selective,

and every attempt to expand benefits has resulted in a paralyzing political battle over who would be added to insurance rolls and who ought to pay for those additions.

Policy is driven by more than politics, however. It is equally driven by ideas, and in the past few decades a particular idea has taken hold among prominent American economists which has also been a powerful impediment to the expansion of health insurance. The idea is known as “moral hazard.” Health economists in other Western nations do not share this obsession. Nor do most Americans. But moral hazard has profoundly shaped the way think tanks formulate policy and the way experts argue and the way health insurers structure their plans and the way legislation and regulations have been written. The health-care mess isn’t merely the unintentional result of political dysfunction, in other words. It is also the deliberate consequence of the way in which American policymakers have come to think about insurance.

“Moral hazard” is the term economists use to describe the fact that insurance can change the behavior of the person being insured. If your office gives you and your co-workers all the free Pepsi you want—if your employer, in effect, offers universal Pepsi insurance—you’ll drink more Pepsi than you would have otherwise. If you have a no-deductible fire-insurance policy, you may be a little less diligent in clearing the brush away from your house. The savings-and-loan crisis of the nineteen-eighties was created, in large part, by the fact that the federal government insured savings deposits of up to a hundred thousand dollars, and so the newly deregulated S. & L.s made far riskier investments than they would have otherwise. Insurance can have the paradoxical effect of producing risky and wasteful behavior. Economists spend a great deal of time thinking about such moral hazard for good reason. Insurance is an attempt to make human life safer and more secure. But, if those efforts can backfire and produce riskier behavior, providing insurance becomes a much more complicated and problematic endeavor.

In 1968, the economist Mark Pauly argued that moral hazard played an enormous role in medicine, and, as John Nyman writes in his book “The Theory of the Demand for Health Insurance,” Pauly’s paper has become the “single most influential article in the health economics literature.” Nyman, an economist at the University of Minnesota, says that the fear of moral hazard lies behind the thicket of co-payments and deductibles and utilization reviews which characterizes the American health-insurance system. Fear of moral hazard, Nyman writes, also explains “the general lack of enthusiasm by U.S. health economists for the expansion of health insurance coverage (for example, national health insurance or expanded Medicare benefits) in the U.S.”

What Nyman is saying is that when your insurance company requires that you make a twenty-dollar co-payment for a visit to the doctor, or when your plan includes an annual five-hundred-dollar or thousand-dollar deductible, it’s not simply an attempt to get you to pick up a larger share of your health costs. It is an attempt to make your use of the health-care system more efficient. Making you responsible for a share of the costs, the argument runs, will reduce moral hazard: you’ll no longer grab one of those free Pepsis when you aren’t really thirsty. That’s also why Nyman says that the notion of moral hazard is behind the “lack of enthusiasm” for expansion of health insurance. If you think of insurance as producing wasteful consumption of medical services, then the fact that there are forty-five million Americans without health insurance is no longer an immediate cause for alarm. After all, it’s not as if the uninsured never go to the doctor. They spend, on average, \$934 a year on medical care. A moral-hazard theorist would say that they go to the doctor when they really have to. Those of us with private insurance, by contrast, consume \$2,347 worth of health care a year. If a lot of that extra \$1,413 is waste, then maybe the uninsured person is the truly efficient consumer of health care.

The moral-hazard argument makes sense, however, only if we consume health care in the same way that we consume other consumer goods, and to economists like Nyman this assumption is plainly absurd. We go to the doctor grudgingly, only because we’re sick. “Moral hazard is overblown,” the Princeton

economist Uwe Reinhardt says. “You always hear that the demand for health care is unlimited. This is just not true. People who are very well insured, who are very rich, do you see them check into the hospital because it’s free? Do people really like to go to the doctor? Do they check into the hospital instead of playing golf?”

For that matter, when you have to pay for your own health care, does your consumption really become more efficient? In the late nineteen-seventies, the RAND Corporation did an extensive study on the question, randomly assigning families to health plans with co-payment levels at zero per cent, twenty-five per cent, fifty per cent, or ninety-five per cent, up to six thousand dollars. As you might expect, the more that people were asked to chip in for their health care the less care they used. The problem was that they cut back equally on both frivolous care and useful care. Poor people in the high-deductible group with hypertension, for instance, didn’t do nearly as good a job of controlling their blood pressure as those in other groups, resulting in a ten-per-cent increase in the likelihood of death. As a recent Commonwealth Fund study concluded, cost sharing is “a blunt instrument.” Of course it is: how should the average consumer be expected to know beforehand what care is frivolous and what care is useful? I just went to the dermatologist to get moles checked for skin cancer. If I had had to pay a hundred per cent, or even fifty per cent, of the cost of the visit, I might not have gone. Would that have been a wise decision? I have no idea. But if one of those moles really is cancerous, that simple, inexpensive visit could save the health-care system tens of thousands of dollars (not to mention saving me a great deal of heartbreak). The focus on moral hazard suggests that the changes we make in our behavior when we have insurance are nearly always wasteful. Yet, when it comes to health care, many of the things we do only because we have insurance—like getting our moles checked, or getting our teeth cleaned regularly, or getting a mammogram or engaging in other routine preventive care—are anything but wasteful and inefficient. In fact, they are behaviors that could end up saving the health-care system a good deal of money.

Sered and Fernandopulle tell the story of Steve, a factory worker from northern Idaho, with a “grotesquelooking left hand—what looks like a bone sticks out the side.” When he was younger, he broke his hand. “The doctor wanted to operate on it,” he recalls. “And because I didn’t have insurance, well, I was like ‘I ain’t gonna have it operated on.’ The doctor said, ‘Well, I can wrap it for you with an Ace bandage.’ I said, ‘Ahh, let’s do that, then.’ ” Steve uses less health care than he would if he had insurance, but that’s not because he has defeated the scourge of moral hazard. It’s because instead of getting a broken bone fixed he put a bandage on it.

At the center of the Bush Administration’s plan to address the health-insurance mess are Health Savings Accounts, and Health Savings Accounts are exactly what you would come up with if you were concerned, above all else, with minimizing moral hazard. The logic behind them was laid out in the 2004 Economic Report of the President. Americans, the report argues, have too much health insurance: typical plans cover things that they shouldn’t, creating the problem of overconsumption. Several paragraphs are then devoted to explaining the theory of moral hazard. The report turns to the subject of the uninsured, concluding that they fall into several groups. Some are foreigners who may be covered by their countries of origin. Some are people who could be covered by Medicaid but aren’t or aren’t admitting that they are. Finally, a large number “remain uninsured as a matter of choice.” The report continues, “Researchers believe that as many as one-quarter of those without health insurance had coverage available through an employer but declined the coverage. . . . Still others may remain uninsured because they are young and healthy and do not see the need for insurance.” In other words, those with health insurance are overinsured and their behavior is distorted by moral hazard. Those without health insurance use their own money to make decisions about insurance based on an assessment of their needs. The insured are wasteful. The uninsured are prudent. So what’s the solution? Make the insured a little bit more like the uninsured.

Under the Health Savings Accounts system, consumers are asked to pay for routine health care with their own money—several thousand dollars of which can be put into a tax-free account. To handle their catastrophic expenses, they then purchase a basic health-insurance package with, say, a thousand-dollar annual deductible. As President Bush explained recently, “Health Savings Accounts all aim at empowering people to make decisions for themselves, owning their own health-care plan, and at the same time bringing some demand control into the cost of health care.”

The country described in the President’s report is a very different place from the country described in “Uninsured in America.” Sered and Fernandopulle look at the billions we spend on medical care and wonder why Americans have so little insurance. The President’s report considers the same situation and worries that we have too much. Sered and Fernandopulle see the lack of insurance as a problem of poverty; a third of the uninsured, after all, have incomes below the federal poverty line. In the section on the uninsured in the President’s report, the word “poverty” is never used. In the Administration’s view, people are offered insurance but “decline the coverage” as “a matter of choice.” The uninsured in Sered and Fernandopulle’s book decline coverage, but only because they can’t afford it. Gina, for instance, works for a beauty salon that offers her a bare-bones health-insurance plan with a thousand-dollar deductible for two hundred dollars a month. What’s her total income? Nine hundred dollars a month. She could “choose” to accept health insurance, but only if she chose to stop buying food or paying the rent.

The biggest difference between the two accounts, though, has to do with how each views the function of insurance. Gina, Steve, and Loretta are ill, and need insurance to cover the costs of getting better. In their eyes, insurance is meant to help equalize financial risk between the healthy and the sick. In the insurance business, this model of coverage is known as “social insurance,” and historically it was the way health coverage was conceived. If you were sixty and had heart disease and diabetes, you didn’t pay substantially more for coverage than a perfectly healthy twenty-five-year-old. Under social insurance, the twenty-five-year-old agrees to pay thousands of dollars in premiums even though he didn’t go to the doctor at all in the previous year, because he wants to make sure that someone else will subsidize his health care if he ever comes down with heart disease or diabetes. Canada and Germany and Japan and all the other industrialized nations with universal health care follow the social-insurance model. Medicare, too, is based on the social-insurance model, and, when Americans with Medicare report themselves to be happier with virtually every aspect of their insurance coverage than people with private insurance (as they do, repeatedly and overwhelmingly), they are referring to the social aspect of their insurance. They aren’t getting better care. But they are getting something just as valuable: the security of being insulated against the financial shock of serious illness.

There is another way to organize insurance, however, and that is to make it actuarial. Car insurance, for instance, is actuarial. How much you pay is in large part a function of your individual situation and history: someone who drives a sports car and has received twenty speeding tickets in the past two years pays a much higher annual premium than a soccer mom with a minivan. In recent years, the private insurance industry in the United States has been moving toward the actuarial model, with profound consequences. The triumph of the actuarial model over the social-insurance model is the reason that companies unlucky enough to employ older, high-cost employees—like United Airlines—have run into such financial difficulty. It’s the reason that automakers are increasingly moving their operations to Canada. It’s the reason that small businesses that have one or two employees with serious illnesses suddenly face unmanageably high health-insurance premiums, and it’s the reason that, in many states, people suffering from a potentially high-cost medical condition can’t get anyone to insure them at all.

Health Savings Accounts represent the final, irrevocable step in the actuarial direction. If you are preoccupied with moral hazard, then you want people to pay for care with their own money, and, when you do that, the sick inevitably end up paying more than the healthy. And when you make people choose an

insurance plan that fits their individual needs, those with significant medical problems will choose expensive health plans that cover lots of things, while those with few health problems will choose cheaper, bare-bones plans. The more expensive the comprehensive plans become, and the less expensive the bare-bones plans become, the more the very sick will cluster together at one end of the insurance spectrum, and the more the well will cluster together at the low-cost end. The days when the healthy twenty-five-year-old subsidizes the sixty-year-old with heart disease or diabetes are coming to an end. “The main effect of putting more of it on the consumer is to reduce the social redistributive element of insurance,” the Stanford economist Victor Fuchs says. Health Savings Accounts are not a variant of universal health care. In their governing assumptions, they are the antithesis of universal health care.

The issue about what to do with the health-care system is sometimes presented as a technical argument about the merits of one kind of coverage over another or as an ideological argument about socialized versus private medicine. It is, instead, about a few very simple questions. Do you think that this kind of redistribution of risk is a good idea? Do you think that people whose genes predispose them to depression or cancer, or whose poverty complicates asthma or diabetes, or who get hit by a drunk driver, or who have to keep their mouths closed because their teeth are rotting ought to bear a greater share of the costs of their health care than those of us who are lucky enough to escape such misfortunes? In the rest of the industrialized world, it is assumed that the more equally and widely the burdens of illness are shared, the better off the population as a whole is likely to be. The reason the United States has forty-five million people without coverage is that its health-care policy is in the hands of people who disagree, and who regard health insurance not as the solution but as the problem. ✦