

## Workers Compensation

"Temporary total disability"

Sustained on the job.

States require employers to carry it.

Replaces about  $\frac{2}{3}$  of wages.

Adverse selection: Private information about danger of work?

Program may be motivated by paternalistic concerns -- people under insure or general sympathy for people who work & get injured, want some redistribution.

Consumption Smoothing:

Lacking any empirical info, do we expect the insurance to provide a benefit that self-insurance doesn't.

People effectively self insure if risks are predictable and consequences in bad state for "C" are small.

Depends on the job and person, but seems like consumption smoothing benefits large/self-insurance possibility weak.

## Moral hazard.

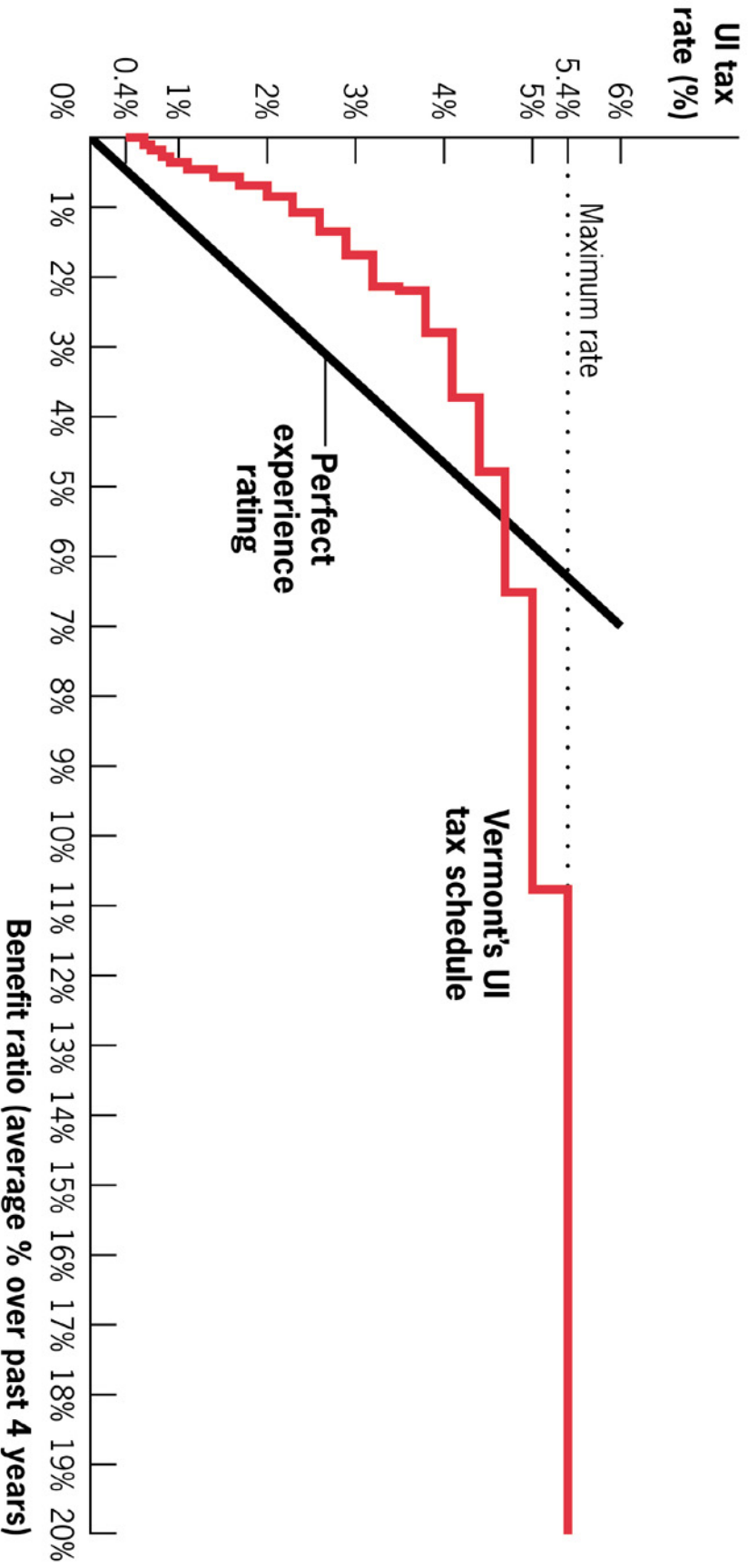
10% ↑ benefits ⇒ 7% ↑  
rate of reported injury.

10% ↑ benefits ⇒ 17% ↑  
injury durations. Higher for hard  
to verify injuries.  
"Monday" effect.

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Employers: WC and UI are  
partially experience rated. Problem.

- Can lead to "subsidized vacations"  
arranged cooperatively between  
employer & employee. (UI)
- Let's marginal, inefficient firms  
survive (UI).
- On WC firms that self-insure,  
duration of injuries much less  
responsive benefits. They seem  
to monitor their injured workers better.



## Health Insurance

Deductibles, Copayments, Co-insurance.

Most private insurance uses  
these mechanisms to control  
moral hazard.

### Employer based.

-- Risk pool gets good  
rates. Employer based risk  
pools not subject to much adverse  
selection, at least for large  
(over 50?) employers.

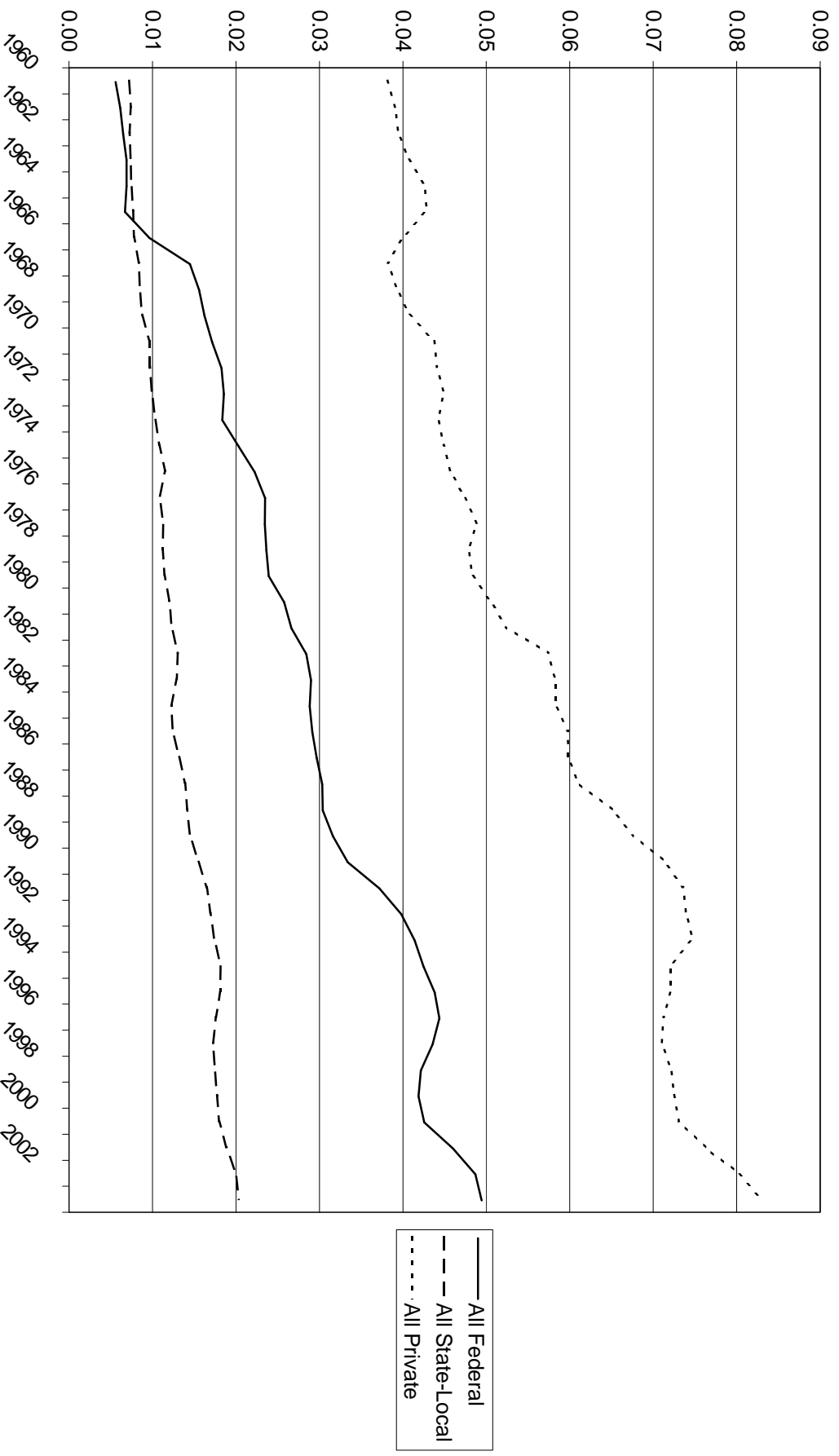
John Edwards has a health  
insurance proposal based on  
regional risk pools.

- Tax advantage to employer  
provided health insurance.  
Every dollar goes to the premium,  
instead of after-tax dollars  
(Self-employed get the same  
tax deal, but not in a good  
risk pool.)

### Sources of Funds for Health Spending (As Shares of Total Health Spending)



### Sources of Funds for Health Spending (As Shares of GDP)



# Disease and Disadvantage in the United States and in England

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**T**HE UNITED STATES HAS A CONSIDERABLY greater expenditure on medical care (US \$5274 per capita) than in the United Kingdom (US \$2164 adjusting for purchasing power).<sup>1</sup> To determine whether that expenditure translates into better health outcomes for the adult US population, data on the degree of morbidity in each country beyond the childhood years are needed.

Given the strong link between socioeconomic position and health in both countries, cross-country comparisons of morbidity should examine variation of morbidity according to comparable measures of socioeconomic position. Cross-country comparison of social differences in illness provides some insight into potential causal explanations. Access to health care is a particular case in point. Although publicly funded health care is available in both countries to citizens older than 65 years, the UK National Health Service has no age criterion for eligibility. Thus, British households are more isolated from any financial impacts of out-of-pocket medical expenses. A similar argument applies to earnings and job losses, for which the more generous UK income maintenance system should mitigate any effects of health changes on income and wealth there compared with what is available in the United States.

We compare measures of morbidity according to 2 salient measures of so-

**Context** The United States spends considerably more money on health care than the United Kingdom, but whether that translates to better health outcomes is unknown.

**Objective** To assess the relative health status of older individuals in England and the United States, especially how their health status varies by important indicators of socioeconomic position.

**Design, Setting, and Participants** We analyzed representative samples of residents aged 55 to 64 years from both countries using 2002 data from the US Health and Retirement Survey (n=4386) and the English Longitudinal Study of Aging (n=3681), which were designed to have directly comparable measures of health, income, and education. This analysis is supplemented by samples of those aged 40 to 70 years from the 1999-2002 waves of National Health and Nutrition Examination Survey (n=2097) and the 2003 wave of the Health Survey for England (n=5526). These surveys contain extensive and comparable biological disease markers on respondents, which are used to determine whether differential propensities to report illness can explain these health differences. To ensure that health differences are not solely due to health issues in the black or Latino populations in the United States, the analysis is limited to non-Hispanic whites in both countries.

**Main Outcome Measure** Self-reported prevalence rates of several chronic diseases related to diabetes and heart disease, adjusted for age and health behavior risk factors, were compared between the 2 countries and across education and income classes within each country.

**Results** The US population in late middle age is less healthy than the equivalent British population for diabetes, hypertension, heart disease, myocardial infarction, stroke, lung disease, and cancer. Within each country, there exists a pronounced negative socioeconomic status (SES) gradient with self-reported disease so that health disparities are largest at the bottom of the education or income variants of the SES hierarchy. This conclusion is generally robust to control for a standard set of behavioral risk factors, including smoking, overweight, obesity, and alcohol drinking, which explain very little of these health differences. These differences between countries or across SES groups within each country are not due to biases in self-reported disease because biological markers of disease exhibit exactly the same patterns. To illustrate, among those aged 55 to 64 years, diabetes prevalence is twice as high in the United States and only one fifth of this difference can be explained by a common set of risk factors. Similarly, among middle-aged adults, mean levels of C-reactive protein are 20% higher in the United States compared with England and mean high-density lipoprotein cholesterol levels are 14% lower. These differences are not solely driven by the bottom of the SES distribution. In many diseases, the top of the SES distribution is less healthy in the United States as well.

**Conclusion** Based on self-reported illnesses and biological markers of disease, US residents are much less healthy than their English counterparts and these differences exist at all points of the SES distribution.

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cioeconomic status (SES)—education and household income—in nationally representative samples in the United States and England. One common prob-

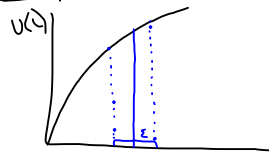
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## ■ TABLE 15-2

### Illustrating the Tax Subsidy to Employer-Provided Insurance

	Marginal product, wage	Employer health insurance spending	Pre-tax wage	After-tax wage	Personal health insurance spending	After-tax, after-health insurance income
Jim	\$30,000	0	\$30,000	\$25,500	\$4,500	\$21,000
Peter	\$30,000	\$5,000	\$25,000	\$21,250	0	\$21,250

## Consumption Smoothing



Loss exceeds gain, but not by much if  $\epsilon$  is small.

⇒ Not much benefit to consumption smoothing, expected utility pretty much the same without the smoothing against small losses in  $C$ .

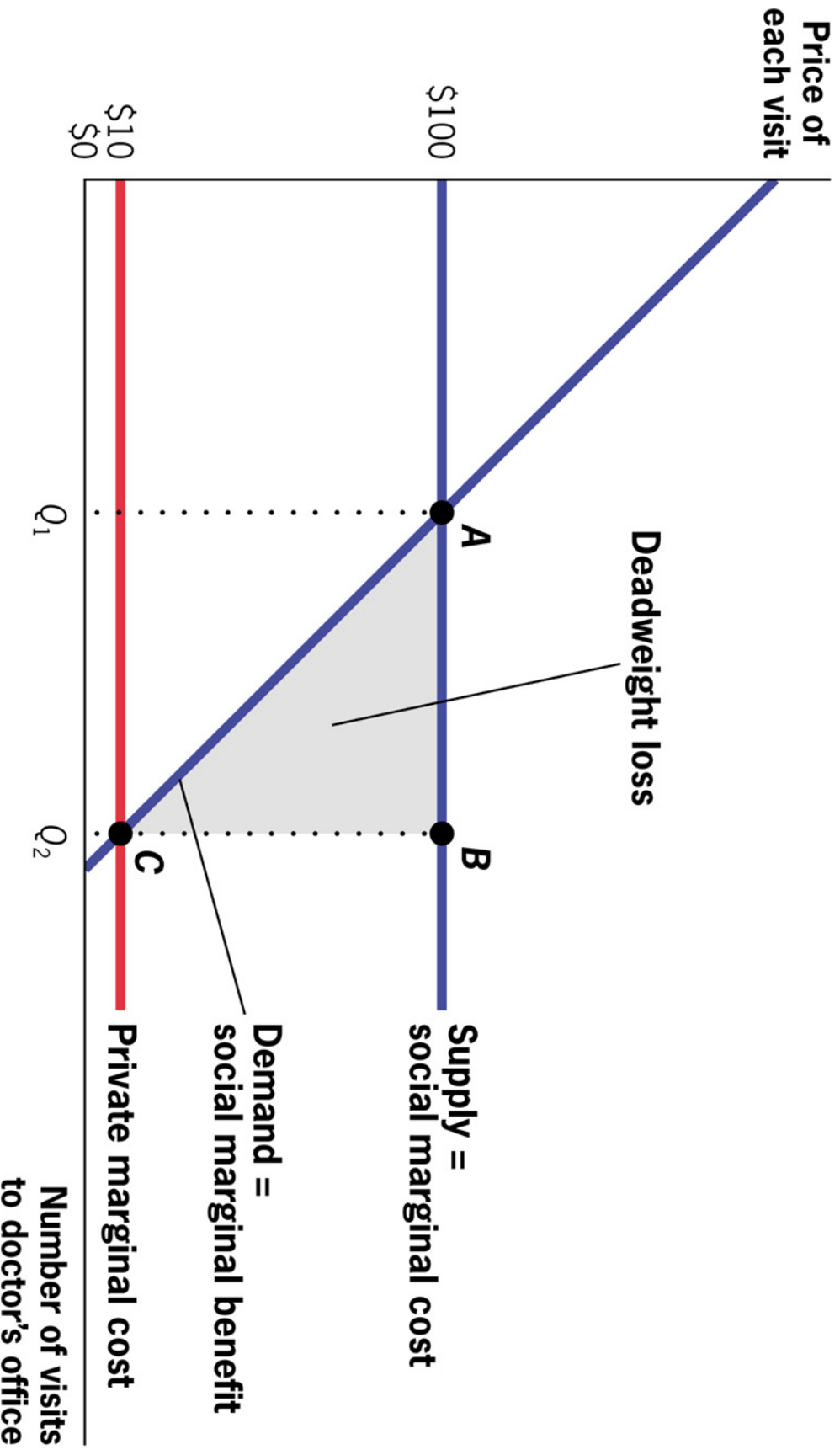
Catastrophic care brings big benefits, not sure about the rest.

## Moral Hazard

Introduces 15.2, but that figure doesn't make sense, and doesn't describe moral hazard.

(I can pay \$100 for a doctor visit without insurance. I have insurance in order to get health care cheaply when I'm ill ⇒ smooth consumption.)

Later: note that moral hazard here is the difference between money you get for care and how much you would want to spend on that care if not required to do so -- could go to Maui, say.



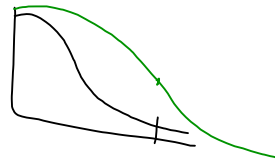
Claim: Because of insurance,  
we are pretending "Flat-of-the-  
curve" health care.



Something wrong with the story  
from a rational choice point of  
view. Could be ok for people getting  
govt. insurance, but people  
working for companies forego  
wages for insurance. Getting  
so much that no benefit?

-- Maybe with health care, like sense  
of security even if doesn't really work.

-- Maybe that you believe  
(perhaps correctly) you won't get newest  
thing unless your coverage puts you  
on the flat of the curve today.



-- People don't know they are on  
the flat of the curve  
Only learn about care & conditions after  
you have something specific.