

MAKING THE PATIENT PAY: A LUDICROUS POLICY

Philippe Batifoulier

▶ **To cite this version:**

Philippe Batifoulier. MAKING THE PATIENT PAY: A LUDICROUS POLICY. Revue du MAUSS, 2013, pp.77-92. 10.3917/rdm.041.0077 . hal-02424730

HAL Id: hal-02424730

https://sorbonne-paris-nord.hal.science/hal-02424730

Submitted on 28 Dec 2019

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

CAIRN.INFO
INTERNATIONAL EDITION

MAKING THE PATIENT PAY: A LUDICROUS POLICY

Philippe Batifoulier

La Découverte | « Revue du MAUSS »

2013/1 No 41 | pages 77 - 92

ISSN 1247-4819
ISBN 9782707176455

This document is a translation of:

Philippe Batifoulier, « Faire payer le patient : une politique absurde », *Revue du MAUSS* 2013/1 (No 41), p. 77-92.
DOI 10.3917/rdm.041.0077

Translated from the French by Cadenza Academic Translations

Available online at :

---

http://www.cairn-int.info/article-E_RDM_041_0077--making-patients-pay-an-absurd-policy.htm

---

How to cite this article :

Philippe Batifoulier, « Faire payer le patient : une politique absurde », *Revue du MAUSS* 2013/1 (No 41), p. 77-92.
DOI 10.3917/rdm.041.0077

Electronic distribution by Cairn on behalf of La Découverte.

© La Découverte. All rights reserved for all countries.
Reproducing this article (including by photocopying) is only authorized in accordance with the general terms and conditions of use for the website, or with the general terms and conditions of the license held by your institution, where applicable. Any other reproduction, in full or in part, or storage in a database, in any form and by any means whatsoever is strictly prohibited without the prior written consent of the publisher, except where permitted under French law.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

Making the Patient Pay: A Ludicrous Policy

Philippe Batifoulier

Making the patient pay is a fashionable strategy, and coinsurance, medical deductibles, and fixed-fee medical billing are systems in widespread use. In France, as elsewhere, the financial contribution of patients towards their own health expenditure has increased considerably, with different situations arising in different countries based on the role played by private health insurance (see, for example, Quesnel-Vallée et al. (2012)).

This strategy is intentional. It is a matter of organizing cuts to healthcare for financial reasons so as to combat waste. The provision of a large national health service is seen to encourage a consumption of care that is of little benefit to people's health. In this context, a national health service is a perverse incentive and it would be better to cut health cover for the benefit of all. Policies in which medical costs are shared with patients (coinsurance, fixed fees, and medical deductibles—see boxed text) do not merely have as their object the occasional saving of a few million euros. Their aim is to discourage healthcare consumption—and this works!

This strategy is indeed effective, as going without care for financial reasons is widespread, as is demonstrated by the Commonwealth Fund survey of 2010, in which 20% of respondents in the United States declared that, during the course of the last twelve months, they had had considerable difficulty in paying their health expenses or had been unable to do so. In the study, France was the European country with the highest rate, with 9%, and the United Kingdom had the lowest, with 2%.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

This strategy has grave political consequences. The belief that health insurance is a problem provides those in opposition to its extension with a valid line of defense. In the United States, this view of health insurance is frequently used in public debate in order to prevent any attempt at extending cover to include the millions of Americans who do without it (Gladwell 2005). In Europe, since health insurance is essentially the responsibility of the state and mandatory, it is its withdrawal that is called for in the name of making the patient responsible. The argument in favor of a free health service therefore comes up against the financial interests of private insurance companies, which benefit from the withdrawal of public health insurance, in order to expand their market. Finally, emphasizing the involvement of the patient's insurance in the abuse of healthcare expenditure, oddly enough, exonerates doctors from any responsibility in this expenditure; it is, in fact, as though the patient is able to benefit from this care without going through a doctor to write out a prescription! Making the patient pay is a strategy illustrative of the situation as regards the power struggles at play in the health-related domain. The political power of doctors (or at least some of them) is unequal to that of their patients.

If the stakes are considerable, the consequences are tragic. Making patients pay is exceedingly detrimental to their state of health, fuelling inequality at the same time as causing new expenses, especially through schemes connected with the referral of healthcare to hospitals. Regardless of the harm, which I will clarify, this remains a strategy that is obstinately pursued by governments. This erroneous tenacity can largely be attributed to the strong theoretical foundations underlying the strategy, which are, however, to a large extent questionable.

The Slogan: Health Must Come at a Price

Standard economic theory is based on an obscure term used to criticize generous health cover, that of moral risk (or moral hazard in the original version), denoting healthcare consumption as a result of medical insurance. The term is all the more puzzling because there is no morality attached to this moral risk, but only rational behavior on the part of the patient. It is to the American economist,

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

Mark V. Pauly (1968), that we are indebted for laying the foundations of the theory of moral hazard in healthcare by endowing it with a negative slant. The idea of moral risk is in fact neutral. It is largely reliant on evidence (we consume more care when we are insured) and no mention is made of whether the consumption of care is justified or otherwise. We might, in fact, highlight the fact of consuming more care thanks to insurance, thus hoping for the existence of a moral risk.

However, Pauly's work would consist in persuading people that this moral risk is to be feared as health insurance lowers the price of the care, making healthcare more attractive to a rational consumer. In a market where commodities and services are bought without insurance, the choice between different commodities is dictated by a consumer's purse and the relationship between the usefulness of the commodity in question and its price. Insurance distorts a behavior perceived to be optimal, since a reduction in price means that more can be bought with the same degree of usefulness. Thus, a budget that has been drained by healthcare might have been used for something else. This incomplete and biased interpretation of moral risk as the classic price effect in consumer standard economic theory results in the loss of collective well-being. Patients benefit from an allocative inefficiency: insurance means that care is free (or affordable) and they, thus, consume even more.

Cost sharing, Excess, and Moral Risk: Some Definitions

The schemes for cost sharing between the insurer and the insured (the patient) are of four types:

– Deterrent fees (or coinsurance), corresponding to a percentage of the care, are widely used in France, Belgium, and Switzerland, both in general medical and specialist practices, as well as for medicines. In Germany, coinsurance is only used for medicines. In the United States, it is frequently used in private insurance and in numerous Medicare services (for patients over sixty-five).

– Copayment, which is a flat-rate contribution independent of cost, corresponds to a fixed-price entry-level cost. This scheme is used almost invariably for hospital care. It corresponds to an inclusive stay or the payment of a flat rate entitling the patient to certain types of healthcare.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

In the United States, copayment for visits to the doctor, paid through health insurance schemes, doubled between 2001 and 2006.

– A deductible is an annual default threshold for admission that is particularly widely used in Switzerland and the Netherlands, and in Sweden, for reimbursable medicines. It has recently made its appearance in France, being used as part of a copayment scheme for medicines and medical transportation. Reimbursement in its entirety is activated beyond an annual threshold of €50.00. Deductibles are in widespread use in the United States in private medical insurance as well as the state-operated Medicare program.

– Reference pricing involves capping the price for medical care paid by the state. The patient pays the difference in price between the cost borne by the state and the actual cost. This scheme is widely used in Europe for medicines.

These schemes increase the excess payment made by patients and it is they who are responsible for the healthcare costs not provided for by the national health service (the *Sécurité Sociale* in France). Increases in the patient's "excess" can be refinanced through private health insurance (in France this is a supplementary medical insurance, through a mutual insurance company for instance) and/or directly taken on by consumers ("out-of-pocket payments"). In all these cases, in the future, patients will have to consider devoting a more significant part of their income to financing their healthcare. This strategy is recommended by the economic theory of moral hazard, which must be distinguished from the notion of moral risk pure and simple. The notion of the patient's moral risk is allied to a healthcare consumption that is caused by a national health service. This notion is neutral and does not refer to the justifiable or unjustifiable nature of this consumption. The standard economic theory of moral hazard puts a negative slant on it: being well insured causes waste.

It is not so much the fact of its being free as its spirit of freedom that is considered to be an aberration. The economic theory of moral hazard is in open conflict with the sentiment so widely shared that health has no price. Such a sentiment imparts something special and noble to healthcare commodities and services. It stands in opposition to a commercialization that aims to put a price on everything and a value on nothing. The fact of its being free upsets the sovereignty of the consumer, making the dreamed-of world in which there is no insurance seem ugly (in theory, the situation in question is effectively one in which there is no health insurance). The "hatred

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

of what is free" (Caillé and Chanial 2010) means that health is undervalued and is relegated to the rank of any old commodity, like cars, where insurance techniques have proved their mettle.

This economic theory of moral hazard goes beyond the simple notion of moral risk. By considering that health insurance is a problem because it leads to unnecessary consumption owing to the fact that it is by and large free, its existence is not under discussion, only its harmfulness. The consequences of this economic policy are immediate: we must reduce a person's health cover and resort to healthcare that is more expensive.

Building a Convenient Fiction

Do patients really behave as though they are freeloaders when it comes to a national health service? This idea is the direct result of the portrayal of people in the standard economic theory, namely, that people are natural opportunists who are capable of anything, including using illness to their own advantage in order to profit from their health cover. The patient here is the individual portrayed in the rational choice theory, according to which people seek to maximize their personal interests in each and every circumstance.

This is why the theory of moral hazard discounts any morality, needing, for the sake of its internal cohesion, to discard any values that might influence the way people behave or render the theory null and void. It aims to prevent opportunism on the part of the insured party, which is considered to be the expected reaction of an individual if he or she is rational and intends to use health insurance to his or her own advantage. All rational individuals act in the same way and there is no need to appeal to an absence of morality for individuals to act as spongers on the national health service. The overconsumption of healthcare is, thus, a characteristic of insurance rather than of the individuals themselves; they are merely reacting to this incentive. If it is insurance that is at fault, the problem must be solved by cutting it back. The recognition of the existence of a "morality" among the stakeholders is potential suicide as far as the theory is concerned. If individuals obey moral obligations or social conventions preventing them from exploiting health insurance, then

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

the fear of overconsumption is no longer justified and it is pointless to make the patient pay.

There is no reason to doubt that individuals are indeed capable of opportunism, but neither should we assume that this is automatically the case when they have an interest in the community in which they live. Social welfare systems highlight a particular type of relationship with others based on giving, bringing the individual's link with society to life by relegating an interest in what is profitable to the background (Caillé 2005). Individuals are not devoid of social responsibility. This is the position adopted by Arrow (1963) when he considers that the fear of a moral risk (an overconsumption of care) can potentially be removed by "social obligations" or "institutions of trust" that are more effective than commercial incentives. It is by rejecting this agreed theory of trust that Pauly would later go on to construct the economic theory of moral hazard with regard to health,[1] endowing it with the negative connotation expressed in policies aimed at making patients pay.

Making the patient pay is a strategy that is founded on a theory in which the patient has no depth. He or she does not make judgments; he or she calculates. This completely self-interested individual does not fit in with a network of social relationships capable of directing his or her behavior, putting the brakes on his or her opportunism. The economic theory of moral hazard is a political and social creation without society. Consequently, it is the vision of social welfare—a national health service in particular—that is misrepresented. In this economics-orientated point of view, national insurance must be concerned with the calculation of individual risk, discarding the aim of a shared world. Self-interest prevents mutual giving—all for each and each for all—represented by national insurance (Chanial 2000). This marginalization of the fundamental characteristics of a national health service enables the creation of a convenient

1. It is of singular interest that the whole theory of health-related moral hazard claims allegiance to Arrow (1963), to whom we are indebted for the popularization of the idea of moral risk, but who is opposed to Pauly's view of it and who persisted in his opposition by emphasizing the role of moral judgments: "Pauly's wording suggests that 'rational economic behavior' and 'moral perfidy' are mutually exclusive categories. No doubt Judas Iscariot turned a tidy profit from one of his transactions, but the usual judgment of his behavior is not necessarily wrong" (Arrow 1968, 538).

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

fiction in which the patient is summed up as a cheat par excellence, someone willing to exploit insurance for his own personal gain.

Sick People with No Sickness?

And yet, the context in which health insurance operates is one of sickness, and it is this which largely negates the opportunism expected of the patient. The cold calculation of the rational patient evaporates in the presence of emotions caused by sickness. A sick person must face up to dread, anguish, and fear, pushing possible overconsumption due to the existence of insurance into the background. These emotions are, to a very large extent, shared ones and uphold a common world that is in conflict with the crazed individualism of a scheming patient.

The economic theory of moral hazard is only applicable to sick people with no sickness. If this is not the case, then the conclusions drawn from it should be largely reassessed. Thus, the theory of moral hazard ex ante (before the illness) takes into consideration the fact that individuals will make no effort to prevent illness when they have effective health cover (insurance encourages risk taking). This idea can be largely scrapped because it is not only financial costs that are incurred by illness. Suffering, disability, and so forth are also involved. These other ill effects are not covered by insurance, however, with only the cost of healthcare being covered. This is why I fail to see where the interests of a patient in neglecting to make any efforts at prevention could possibly lie, efforts that would affect his or her own well-being and quality of life. Does a well-insured patient indulge in risk taking because he or she knows that, in the future, his cirrhosis or lung cancer will be treated? Someone with full medical coverage will rationally make preventative efforts; otherwise he or she would be gambling with his or her future health and his or her inclusion in the labor market. I fail to see, therefore, how full coverage can adversely affect preventative behaviors. In fact, the very opposite seems to be the case, with those with the best insurance taking the greatest care to prevent sickness. The theory of moral hazard ex ante is dangerous, moreover, if reduced coverage is capable of discouraging prevention. In fact, the voluntary act of prevention involves greater sensitivity to the cost of healthcare,

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

especially owing to the fact that a more far-sighted view of the benefits of preventative care is taken in relation to curative care. It is, thus, the flat fees, the coinsurance, and the deductibles that are detrimental to prevention rather than the opposite, as is claimed by the theory (Batifoulier 2002).

If we focus on the theory of moral hazard *ex post* (after the illness), according to which insurance leads to an overconsumption of healthcare, we might also have serious doubts concerning its veracity. It is only the sick who claim on their insurance. The healthy do not need healthcare even if there is nothing to pay. Indeed, everyone is not clamoring for a triple bypass operation just because it is free and we might well be skeptical concerning the pleasure taken from waiting six hours in the ER purely because it is free. Health-related economics revealed very late (with Nyman (1999)) what patients had long known, namely that insurance enables access to care that is impossible without it. It *provides* the financial resources necessary to get better. It cannot be reduced to a problem of a cost that is so low that it means that those who are healthy use it, as is claimed by the standard economic theory. It is billed even more as a supplementary revenue offered to the sick in order to satisfy a need to which only healthcare is able to respond. It is the prohibitive excess fees that dissuade individuals from seeking treatment. By reducing them, insurance ensures that healthcare consumption, restrained until then, is effective.[2]

Paying Is Seriously Detrimental to People's Health

One of the strong points of the economic theory of moral hazard was that it demonstrated empirically that cost-sharing policies had no impact on the state of health. This was the chief contribution of the study carried out by the Rand Corporation (*Health Insurance*

2. The empirical study carried out by Pierre et al. (2012) shows that a subscription to a more inclusive form of health insurance is accompanied by an increase in excess fees, since extra insurance enables access to care that was previously too expensive, namely dental and eye treatment. Supplementary insurance does not therefore diminish the financial risk. Neither does it lead to unnecessary expenditure. It enables the satisfaction of a demand that is too expensive without adequate insurance cover.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

Experiment), sponsored by the US federal government in 1974, in which the effect of an organized reduction of the amount of health insurance on the health of numerous patients was measured by randomly distributing insurance policies with varying coinsurance rates (from 0% to 95%). Paying evidently meant taking less care, with economists referring to a price elasticity of –0.2: for a rise of 10% in the cost paid by the patient, the demand for care (recourse to a doctor) was reduced by 2%. The crux of the matter lies elsewhere, however. The study showed above all that a reduction in insurance in the order of 25% posed no threat to an individual's health (Manning et al. 1987; Newhouse et al. 1993).[3] It, therefore, secured a policy in which costs were shared with the patient and legitimized the existence of deterrent fees, copayments, and deductibles as a means of cutting health insurance. This study is the only large-scale enquiry ever realized and it is not likely to be repeated owing to its very high cost (to the order of fifty million dollars). It, therefore, remains the point of reference on which all those who believe that it is appropriate to ask for contributions from patients rely.

With Pauly's theory, this empirical study represents the intellectual framework behind policies that aim to make the patient pay. The empirical proof is as flawed as the theoretical approach is deficient. Firstly, the empirical evidence seems unreliable, leading to results today that are in direct opposition to those of the Rand Corporation. A first wave of criticisms relates to its methodological bias. The individuals, who agreed to participate in the experiment, were those who did not anticipate any specific health issues. Anticipating

3. The insurance policies were allocated randomly using a sample of six thousand people (under sixty-five) followed for between three and five years. The results showed that many people did not need healthcare for a year (this was the case for ambulatory care and even more so for hospital treatment), as well as showing a drop in costs (that is, recourse to a doctor) in the case even of relatively limited coinsurance. This reduction in consumption is not linear. It reached 30% with a coinsurance rate of 95% and 20% with a coinsurance rate of 25%. The effect was thus more marked from 0% to 25% than for an increase from 25% to 50% or 95%. The reduction in costs was more evident regarding ambulatory care than for hospital treatment, where coinsurance was less effective. After a medical checkup (visual acuity, tooth decay, blood pressure, and so forth), the study concluded that there was an absence of palpable improvement in the state of health as a result of insurance cover except for the two first income deciles (the least well off).

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

health-related costs, the others (elective surgery, pregnancy, and so forth) were unwilling to allow themselves to be allocated an insurance policy with a high rate of coinsurance. This "attrition bias" meant that the study measured, above all, the effect of a reduced health cover on a population of healthy people, a factor that skewed the results (see: Nyman 2007). The empirical results of the Rand Corporation study are, in addition, flawed with respect to the health assessments given by doctors during medical examinations (measuring blood pressure for example), while it is now agreed in medical literature that health should be measured based on an assessment provided by patients concerning their own health. A utilitarian approach to care based on quantifiable measurement does not correspond to the outlook concerning their health provided by patients. In addition, health cannot be reduced to short-term measurement and the Rand Corporation study did not take the long-term effects of the deprivation of healthcare into account. Finally, the care available during the 1970s was less effective than it is today, in particular with respect to the treatment of chronic disease, contributing to the effects of care on people's health being underestimated.

Doubts concerning the viability of the Rand Corporation study were then consolidated following numerous studies being in agreement in their placing an emphasis on the negative effects of cost-sharing insurance policies on people's health. The strategy, which involves making patients pay, is based on the belief that nonessential care, which does not contribute to improving the state of an individual's health, should bear the cost. This belief is utterly without foundation. When the patient is made to pay for his or her own healthcare, all care deteriorates, including care that is essential to health. Cost-sharing policies are oblivious of the different types of care and cutting care does not exclude essential care, as is evidenced by a large number of empirical studies carried out in the United States (Chandra et al. 2010; Trivedi et al. 2010), Canada (Tamblyn et al. 2001), and France (Dourgnon et al. 2012). Consequently, making the patient pay is a ludicrous strategy owing to the fact that it leads to an increase in the very costs that it was intended to reduce. Indeed, just as the organized cutting of care causes harm to the health, it also leads to "undesirable events" such as delayed care, treatment being substituted for medication

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

that is better funded but dangerous to the patient's health,[4] a more frequent use of emergency services, and a rise in hospitalization, especially in the form of long stays.

These consequences are inconvenient for those involved. They are also counterproductive as far as public policy is concerned since they create new expenditure. The harmful effects of cost-sharing policies on people's health are reflected by an increase in the overall cost of care, as is shown in the more recent studies carried out by the Rand Corporation (McGlynn 1998; Goldman et al. 2006): cutting coinsurance on cholesterol-lowering drugs might improve the health of patients at the same time as saving more than a billion dollars in medical costs every year, by increasing patient compliance as far as treatments are concerned, and reducing the risk of hospitalization.

Patient Poverty and the Benefits of Medical Insurance

The harm wrought by cost-sharing policies is all the greater since it is the worst off who are the main victims. In fact, insofar as inequalities in terms of health are above all social inequalities, the sickest are primarily the worst off. The existence of a "social gradient" means that the best off are freer from disease than the worst off (Fassin 2009; Lang, Grémy, and Jougla 2011). Moreover, flat-rate payments, coinsurance, and other deductibles mean that it is only the sick— and thus the worst off—that pay. It follows, therefore, that those who are worse off need to visit doctors more, although actual recourse to them is observed more among the better off (Devaux and de Looper 2012).

This situation, which is widespread in Europe, is particularly marked in France, especially in terms of specialist treatment and prevention. Moreover, a lower instance of visiting a doctor is

4. The negative effect on the health of reducing medicine reimbursement has been observed in France (Pichetti and Sermet 2011). Reduced reimbursement leads to substituting prescribed medicines for the types of treatment that are still reimbursed, causing problems both to public health and the financial efficacy of the measures (substitution for types with better reimbursement). For example, the abandonment of venotonic drugs is reflected in the overprescription of nonsteroidal and antalgic anti-inflammatories. The substitution of mucolytic drugs by bronchodilators and antitussives can be dangerous to an individual's health.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

damaging to people's health and a late appeal for treatment for what is referred to as repair is more expensive for the community as a whole. The causes of the inequality as far as access to care is concerned can largely be attributed to the health cover of the person who is sick (Desprès et al 2011). Individuals are not insured in accordance with their risk, but their income. Those on the highest incomes and those who have the best positions in the labor market have the most insurance cover (Domin 2010; Batifoulier et al 2010). Those who have the greatest need for a secure access to treatment are also the least protected by their health insurance.

Inequalities in terms of access to healthcare cannot counteract inequalities in the state of health; in fact, they make them worse. In this situation, the populations with the worst state of health are those which suffer most from the effects of cost-sharing policies. By making care more expensive for everyone, and especially for the least well off, who are also the sickest, these policies mean that they have to devote a more significant portion of their income to healthcare and, thus, to sacrifice other items of consumption, some of which are more useful for their health, namely nutrition, hygiene, and accommodation. The deterioration in the state of health of the most vulnerable is a cause of negative externality in society. In addition to the threat posed to the health of individuals themselves, the introduction of financial barriers in terms of access to healthcare may result in a collective risk posed by the spread of diseases and the deterioration of communal well-being, necessitating new public expenditure (Castiel and Bréchat 2010; Tabuteau 2011; Batifoulier and Parel 2012).

Therefore, rather than being a problem, health insurance is a solution above and beyond an improvement in the state of health. The experiment carried out in the state of Oregon in 2008 is testimony to this. A certain number of individuals won a medical insurance policy through a lottery and it was possible to observe their behavior as a result of the insurance and compare it with that of the "losers"[5] (Newhouse et al. 2012; Baicker and Finkelstein 2011).

5. The Oregon Health Plan Standard aimed to provide the worst-off inhabitants, chosen at random, with insurance through an extension of Medicaid: ninety thousand adults on low incomes, who did not fulfil the required criteria for eligibility to Medicaid, volunteered for the lottery for ten thousand available places.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

As expected, the existence of health cover increased the probability of the access to healthcare for all types of care except emergencies,[6] leading to a 25% increase in costs. The study showed that the state of health improved significantly. Care is, therefore, not unnecessary and answers to a genuine need. The number of days taken off sick diminished and the people who were newly insured declared that, henceforth, and more often than before, a regular place would be reserved for healthcare and the services of a general practitioner.

Having health cover not only has a positive effect on the health, but also leads to better general welfare. This is proved in the experiment by showing that health insurance increases well-being by making the lives of individuals secure so that they are able to honor their debts (a reduction of 40% in the probability of not honoring one's debts)[7] and consume more, whatever their health problems. The fact that medical costs are dealt with minimizes anxiety concerning the future and enables individuals to manage their existence better. This effect is very striking and shows that healthcare is a door into care in general so that people are then able to pay attention to poverty and social exclusion through healthcare. In return, a feeling of well-being and being in control of one's life has an impact on the state of one's health insofar as insecurity fosters inequality, as is demonstrated in Wilkinson's work (2009). Extra health cover, therefore, has a positive effect on the state of the health of the population and is likely to reduce the costs connected with illness over time.

Health insurance, like social insurance in general, contributes to better welfare in the general population. By distributing benefits, which go above and beyond health, a national health service engenders social ties and ensures collective progress. This ambition is a political creation, however, rather than a natural given. By the skilful pretense that health insurance constituted a problem, the economic theory of moral hazard succeeded in eroding the common good as

6. Medicaid health cover increases the likelihood of using external consultation services by 35%, prescribed medicines by 15%, and hospitalization by 30%. Preventive care was higher than for those without cover (a rise of 60% for mammograms, and 20% for cholesterol control). In total, primary healthcare increased by 50%.

7. Outstanding medical debts have become a reality in numerous cases, without reaching the same level as the United States, where health expenditure is the primary cause of personal financial ruin.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

an aim. The use of cost-sharing schemes was recommended as a result of the connection between insurance and waste, encouraging the patient to abandon an unjustified consumption of healthcare. This idea leads structurally to greater inequality. Financial barriers to the healthcare system deprive those who need it most of access to healthcare. Necessary healthcare is prevented by the desire to eradicate unnecessary care. It is both a ludicrous and counterproductive strategy since it costs the community dear at the same time as destroying social cohesion.

References

Arrow, Kenneth J. 1963. "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53: 941–973.

——. 1968. "The Economics of Moral Hazard: Further Comment." *American Economic Review* 58: 537–539.

Baicker, Katherine, and Amy Finkelstein. 2011. "The Effects of Medical Coverage: Learning from the Oregon Experiment." *The New England Journal of Medicine* 20: 683–685. doi: 10.1056/NEJMp1108222.

Batifoulier, Philippe. 2012. "De la responsabilité individuelle aux priorités collectives. Une analyse institutionnaliste des politiques de la demande en santé." *Éthique et Économique /Ethics and Economics* 9, no. 2: 25–44. http://hdl.handle.net/1866/8385.

——, Jean-Paul Domin, and Philippe Abecassis.2010. "Les Effets pervers de la politique incitative: l'exemple de l'assurance maladie complémentaire." *Économie Appliqée* 4: 171–194.

——, and Véronique Parel. 2012. "La Prise en charge médicale des personnes précaires: une nécessité économique." In *Innover contre les inégalités de santé*, edited by Pierre-Henri Bréchat and Jacques Lebas, 59–70. Rennes, France: Presses de L'EHESP.

Caillé, Alain. 2005. *Dé-penser l'économique. Contre le fatalisme*. Paris: La Découverte.

–––, and Philippe Chanial. 2010. "Présentation." *Revue du MAUSS Semestrielle* 35: 5–34.

Castiel, Didier, and Pierre-Henri Bréchat. 2010. *Solidarité, précarité et handicap social*. Rennes, France: Presses de L'EHESP.

Chandra, Amitabh, Jonathan Gruber, and Robin McKnight. 2010. "Patient Cost-sharing and Hospitalization Offsets in the Elderly." *American Economic Review* 100, no. 1: 193–213. doi: 10.1257/aer.100.1.193.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

Chanial, Philippe. 2008. “Donner aux pauvres.” In *La Société vue du don. Manuel de sociologie anti-utilitariste appliquée*, edited by Philippe Chanial, 272–304. Paris: La Découverte.

Commonwealth Fund. 2010. “2010 International Health Policy Survey in Eleven Countries: Chartpack.” New York: Commonwealth Fund.

Desprès, Caroline, Paul Dourgnon, Romain Fantin, and Florence Jusot. 2011. “Le Renoncement aux soins pour raisons financières: une approche socio-anthropologique.” *Questions d’Économie de la Santé* 169.

Devaux, Marion, and Michael de Looper. 2012. “Income-Related Inequalities in Health Service Utilization in 19 OCDE Countries, 200 –2009.” OECD Health Working Papers 58, OECD, Paris, France. http://dx.doi.org/10.1787/5k95xd6stnxt-en.

Domin, Jean-Paul. 2010. “L’Assurance maladie complémentaire, vecteur de la reproduction des inégalités dans l’emploi.” *Les Notes de l’IES* 14.

Dourgnon, Paul, Florence Jusot, and Romain Fantin. 2012. “Payer peut nuire à votre santé: une étude de l’impact du renoncement financier aux soins sur l’état de santé.” Working paper, IRDES Document de Travail 47, IRDES, Paris.

Fassin, Didier. 2009. “Inégalités de santé.” *Problèmes politiques et sociaux* 960.

Gladwell, Malcolm. 2005. “The Moral-Hazard Myth. The Bad Idea behind our Failed Health-Care System.” *The New Yorker*, August 29.

Goldman, Dana P., Geoffrey F. Joyce, and Pinar Karaka-Mandic. 2006. *Cutting Drug Co-Payments for Sicker Patients on Cholesterol-Lowering Drugs Could Save a Billion Dollars Every Year*. Washington, DC: Rand Health. https://www.rand.org/pubs/research_briefs/RB9169.html.

Lang, Thierry, Isabelle Grémy, and Eric Jougla, eds. 2011. “Les inégalités sociales de santé.” Special issue, *Bulletin Epidémiologique Hebdomadaire* 8–9.

Manning, Willard G., Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M S Marquis. 1987. “Health Insurance and the Demand for Medical Care: Evidence from Randomized Experiment.” *American Economic Review* 77: 251–277.

McGlynn, Elizabeth A. 1998. *Assessing the Appropriateness of Care: How Much is Too Much?* Washington, DC: Rand Health. http://www.rand.org/pubs/research_briefs/RB4522l

Newhouse, Joseph P., and the Insurance Experiment Group. 1993. *Free for All? Lessons from the Rand Health Insurance Experiment*. Cambridge, MA: Harvard University Press.

Newhouse, Joseph P., Heidi Allen, Katherine Baicker, and the Oregon Health Study Group. 2012. “The Oregon Health Insurance Experiment:

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte

Evidence from the First Year." *Quarterly Journal of Economics* 127, no. 3: 1057–1106.

Nyman, John A. 1999. "The Value of Health Insurance: The Access Motive." *Journal of Health Economics* 18: 141–152.

Nyman, John A. 2007. "American Health Policy: Cracks in the Foundation." *Journal of Health Politics* 32, no. 5: 759–783, doi: 10.1215/03616878-2007-029.

Pauly, Mark V. 1968. "The Economics of Moral Hazard. Comment." *American Economic Review* 58: 531–537. http://www.jstor.org/stable/1813785.

Pichetti, Sylvain, and Catherine Sermet. 2011. "Le Déremboursement des médicaments en France entre 2002 et 2011: éléments d'évaluation." *Questions d'Économie de la Santé* 167.

Pierre, Aurélie, Anne Gosselin, Marc Perronnin, and Carine Franc. 2012. "Impact d'une sur assurance santé sur le reste à charge des patients." *Économie Publique* 28–29: 149–164.

Quesnel-Vallée, Amélie, Emilie Renahy, Tania Jenkins, and Helen Cerigo. "Assessing Barriers to Health Insurance and Threats to Equity in Comparative Perspective: The Health Insurance Access Database." *BMC Health Services Research* 12, no. 107: 1–12. doi:10.1186/1472-6963-12-107.

Tabuteau, Didier. 2011. "Santé et assurance maladie: l'inquiétante dilution des services publics." *Droit Social* 12: 1277–1282.

Tamblyn, Robyn, et al. "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons." *Journal of the American Medical Association* 285, no. 24–31: 421–429. doi:10.1001/jama.285.4.421

Trivedi, Amal N., Husein Moloo, and Vincent Mor. 2010. "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly." *New England Journal of Medicine* 362, no. 28: 320–328.

Wilkinson, Richard. 2009. *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London: Allen Lane.

Document downloaded from www.cairn-int.info - - Batifoulier Philippe - 93.19.60.143 - 24/05/2015 09h41. © La Découverte