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*Everyone knows that people without health insurance are more likely to die. But are they?*

***by Megan McArdle***

# Myth Diagnosis

IMAGE CREDIT: EDEL RODRIGUEZ

OUTSIDE OF THE few states where it is illegal to deny coverage based on medical history, I am probably uninsurable. Though I'm in pretty good health, I have several latent conditions, including an autoimmune disease. If I lost the generous insurance that I have through *The Atlantic*, even the most charitable insurer might hesitate to take me on.

So I took a keen interest when, at the fervid climax of the health-care debate in mid-December, a *Washington Post* blogger, Ezra Klein, declared that Senator Joseph Lieberman, by refusing to vote for a bill with a public option, was apparently "willing to cause the deaths of hundreds of thousands" of uninsured people in order to punish the progressives who had opposed his reelection in 2006. In the ensuing blogstorm, conservatives condemned Klein's "venomous smear," while liberals solemnly debated the circumstances under which one may properly accuse one's opponents of mass murder.

But aside from an exchange between Matthew Yglesias of the Center for American Progress and Michael Cannon of the Cato Institute, few people addressed the question that mattered most to those of us who cannot buy an individual insurance

policy at any price—the question that was arguably the health-care debate's most important: Was Klein (not to mention other like-minded editorialists who cited similar numbers) *right*? If we lost our insurance, would this gargantuan new entitlement really be the only thing standing between us and an early grave?

Perhaps few people were asking, because the question sounds so stupid. Health insurance buys you health care. Health care is supposed to save your life. So if you don't have someone buying you health care well, you can complete the syllogism.

Last year's national debate on health-care legislation tended to dwell on either heart-wrenching anecdotes about costly, unattainable medical treatments, or arcane battles over how many people in the United States lacked insurance. Republicans rarely plumbed the connection between insurance and mortality, presumably because they would look foolish and heartless if they expressed any doubt about health insurance's benefits. It was politically safer to harp on the potential problems of government interventions—or, in extremis, to point out that more than half the uninsured were either affluent, lacking citizenship, or already eligible for government programs in which they hadn't bothered to enroll.

Even Democratic politicians made curiously little of the plight of the uninsured. Instead, they focused on cost control, so much so that you might have thought that covering the uninsured was a happy side effect of really throttling back the rate of growth in Medicare spending. When progressive politicians or journalists did address the disadvantages of being uninsured, they often fell back on the same data Klein had used: a 2008 report from the Urban Institute that estimated that about 20,000 people were dying every year for lack of health insurance.

But when you probe that claim, its accuracy is open to question. Even a rough approximation of how many people die because of lack of health insurance is hard to reach. Quite possibly, lack of health insurance has no more impact on your health than lack of flood insurance.

Part of the trouble with reports like the one from the Urban Institute is that they cannot do the kind of thing we do to test drugs or medical procedures: divide people randomly into groups that do and don't have health insurance, and see which group fares better. Experimental studies like this would be tremendously expensive, and it's hard to imagine that they'd attract sufficient volunteers. Moreover, they might well violate the ethical standards of doctors who believed they were condemning the uninsured patients to a life nasty, brutish, and short.

So instead, researchers usually do what are called "observational studies": they take data sets that include both insured and uninsured people, and compare their health outcomes—usually mortality rates, because these are unequivocal and easy to measure. For a long time, two of the best studies were Sorlie et al. (1994), which used a large sample of census data from 1982 to 1985; and Franks, Clancy, and Gold (1993), which examined a smaller but richer data set from the National Health and Nutrition Examination Survey, and its follow-up studies, between 1971 and 1987. The Institute of Medicine used the math behind these two studies to produce a 2002 report on an increase in illness and death from lack of insurance; the Urban Institute, in turn, updated those numbers to produce the figure that became the gold standard during the debate over health-care reform.

The first thing one notices is that the original studies are a trifle elderly. Medicine has changed since 1987; presumably, so has the riskiness of going without health insurance. Moreover, the question of who had insurance is particularly dodgy: the studies counted as "uninsured" anyone who lacked insurance in the initial interview. But of course, not all of those people would have stayed uninsured—a separate study suggests that only about a third of those who reported being uninsured over a two-year time frame lacked coverage for the entire period. Most of the "uninsured" people probably got insurance relatively quickly, while some of the "insured" probably lost theirs. The effect of this churn could bias your results either way; the inability to control for it makes the statistics less accurate.

The bigger problem is that the uninsured generally have more health risks than the rest of the population. They are poorer, more likely to smoke, less educated, more likely to be unemployed, more likely to be obese, and so forth. All these things are known to increase your risk of dying, independent of your insurance status.

There are also factors we can't analyze. It's widely believed that health improves with social status, a quality that's hard to measure. Risk-seekers are probably more likely to end up uninsured, and also to end up dying in a car crash—but their predilection for thrills will not end up in our statistics. People who are suspicious of doctors probably don't pursue either generous health insurance or early treatment. Those who score low on measures of conscientiousness often have trouble keeping jobs with good health insurance—or following complicated treatment protocols. And so on.

The studies relied upon by the Institute of Medicine and the Urban Institute tried to control for some of these factors. But Sorlie et al.—the larger study—lacked data on things like smoking habits and could control for only a few factors, while Franks, Clancy, and Gold, which had better controls but a smaller sample, could not, as an observational study, categorically exclude the possibility that lack of insurance has no effect on mortality at all.

The possibility that no one risks death by going without health insurance may be startling, but some research supports it. Richard Kronick of the University of California at San Diego's Department of Family and Preventive Medicine, an adviser to the Clinton administration, recently published the results of what may be the largest and most comprehensive analysis yet done of the effect of insurance on mortality. He used a sample of more than 600,000, and controlled not only for the standard factors, but for how long the subjects went without insurance, whether their disease was particularly amenable to early intervention, and even whether they lived in a mobile home. In test after test, he found no significantly elevated risk of death among the uninsured.

This result is not, perhaps, as shocking as it seems. Health care heals, but it also kills. Someone who lacked insurance over the past few decades might have missed taking their Lipitor, but also their Vioxx or Fen-Phen. According to one estimate, 80,000 people a year are killed just by "nosocomial infections"—infections that arise as a result of medical treatment. The only truly experimental study on health insurance, a randomized study of almost 4,000 subjects done by Rand and concluded in 1982, found that increasing the generosity of people's health insurance caused them to use more health care, but made almost no difference in their health status.

If gaining insurance has a large effect on people's health, we should see outcomes improve dramatically between one's early and late 60s. Yet like the Kronick and Rand studies, analyses of the effect of Medicare, which becomes available to virtually everyone in America at the age of 65, show little benefit. In a recent review of the literature, Helen Levy of the University of Michigan and David Meltzer of the University of Chicago noted that the latest studies of this question "paint a surprisingly consistent picture: Medicare increases consumption of medical care and may modestly improve self-reported health but has no effect on mortality, at least in the short run."

Of course, that might be an indictment of programs like Medicare and Medicaid. Indeed, given the uncertainties about their impact on mortality rates—uncertainties that the results from Sorlie et al. don't resolve—it's possible that, by blocking the proposed expansion of health care through Medicare, Senator Lieberman, rather than committing the industrial-scale slaughter Klein fears, might not have harmed anyone at all. We cannot use one study to "prove" that having government insurance is riskier than having none. But we also cannot use a flawed and conflicting literature to "prove" that Lieberman was willing to risk the deaths of hundreds of thousands. Government insurance should have some effect, but if that effect is not large enough to be unequivocally evident in the data we have, it must be small.

Even if we did agree that insurance rarely confers significant health benefits, that would not necessarily undermine the case for a national health-care program. The academics who question the mass benefits of expanding coverage still think that doing so improves outcomes among certain vulnerable subgroups, like infants and patients with HIV. Besides, a national health program has nonmedical benefits. Leaving tens of millions of Americans without health insurance violates our sense of equity—and leaves those millions exposed to the risk of mind-boggling medical bills.

But we should have had a better handle on the case for expanded coverage—and, more important, the evidence behind it—before we embarked on a year-long debate that divided our house against itself. Certainly, we should have had it before Congress voted on the largest entitlement expansion in 40 years. Unfortunately, most of us forgot to ask a fundamental question, because we were certain we already knew the answer. By the time we got around to challenging our assumptions, it was too late to do anything except scream at each other from the sidelines.

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