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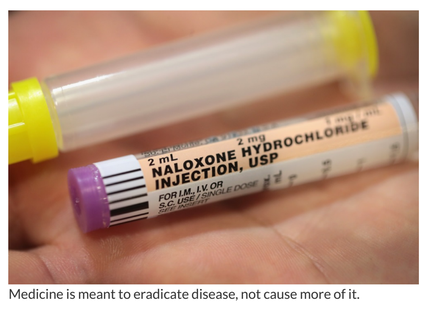
Moral Hazard vs Morality Approaches in the Opioid Crisis

Tafari Mbadiwe, MD, JD



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Medicine is meant to eradicate disease, not cause more of it. So earlier this year, when economists Jennifer L. Doleac and Anita Mukherjee published a paper suggesting that widening naloxone access in urban communities might actually increase opioid abuse, physicians across the United States found themselves in the unfamiliar position of having to defend the use of a lifesaving medication.[1]

No punches were pulled. "Until now, I had not realized that economists and public policy experts were in the habit of advocating, if obliquely, for de facto death sentences for opioid-related crimes," wrote Jeremy Faust, MD, a prominent emergency physician, in a widely circulated takedown of the study published in *Slate*.[2] The study authors, meanwhile, insisted that they were merely dispassionate purveyors of statistical truths. Clear battle lines were drawn: economists on 1 side, physicians on the other. Either the numbers don't lie, or they tell nothing but lies.

For all the consternation it caused, the argument presented by Ms Doleac and Ms Mukherjee is actually fairly straightforward: because naloxone prevents overdoses, it also nudges users toward riskier behaviors, which has the overall effect of increasing opioid use. Naloxone acts as a sort of safety net for opioid users: if they go too far, naloxone will be there to catch them. But because users (and, potentially, would-be users) are aware of the safety net, they respond by taking more heroin or fentanyl or OxyContin than they otherwise would. Naloxone insures users against the risk for overdose, so they take more risks.

Economists refer to the idea that insurance can encourage risk-taking as "moral hazard." The notion that moral hazard might affect medical decision making was first broached in 1968 by economist Mark Pauly in an essay arguing that comprehensive, zero out-of-pocket-cost health insurance would lead to inefficient consumption of healthcare resources.[3] Mr Pauly's piece has been thoroughly criticized, and not just because it seems to assume that we'd all happily check ourselves into the hospital indefinitely, if only we could afford it. Still, it's probably the single most influential article in healthcare economics, and its conclusions are the intellectual scaffolding for the labyrinth of copays and deductibles that American physicians and patients know all too well.[4]

Intentionally or not, Mr Pauly's characterization of healthcare consumption as a moral hazard problem stands in opposition to the concept of preventative medicine. Mr Pauly says as much: his analysis explicitly "excludes preventative medicine from consideration."[3] In Mr Pauly's estimation, healthcare with no out-of-pocket costs would cause people to go to their physician when they didn't strictly need to, which he viewed as an inefficient and wasteful allocation of capital. That's why his paper stumps for copays and deductibles: raising the point-of-sale costs of going to the physician might make people think twice before they waste precious resources on a nonailment.

Advocates of preventative medicine actually agree with Mr Pauly up to a point. Both sides recognize that lower up-front costs promote nonemergent healthcare usage, but see that extra consumption as an opportunity to identify minor problems before they become major ones. They believe that an ounce of prevention is worth a pound of cure. It's tough to reconcile the 2 views; you more or less have to pick 1 side or the other.

Exactly what the optimal approach to the opioid crisis looks like has a lot to do with whether it's a moral hazard problem or a preventative medicine problem. Moral hazards call for deterrence, and in those circumstances, risk mitigation efforts such as increasing naloxone availability only exacerbate the issue by pushing users toward riskier and risker behavior, meaning that it's better to disrupt the supply chain in the hopes that the drugs never make it to the street in the first place. Connecticut, for example, has drastically increased its prosecution of low-level opioid retailers, with the intention of making it more difficult for users to obtain drugs.[5] That makes sense, as long as the opioid epidemic is mostly a moral hazard problem and if we're comfortable regarding narcotic addicts as criminals. In contrast, states such as Maryland and North Carolina have broadened the availability of naloxone, which is what you should do if opioids are a preventative medicine problem and its users are patients who should be treated by physicians. So which is it?

Actually, it's both. The study by Ms Doleac and Ms Mukherjee ultimately found that a region's response to expanded naloxone availability depended largely on the presence of opioid treatment facilities in the area. In cities with many of those facilities, making naloxone more accessible decreased opioid use and related crime; in areas with fewer centers, the opposite happened. It's not hard to see why: If there are no treatment facilities around, an emergency naloxone shot saves a life but also reiterates the availability of an overdose safety net, and maybe even quietly suggests taking a bigger dose the next time around. Moral hazard abounds. But if there are treatment beds available, a lifesaving dose of naloxone might well lead to in-patient rehabilitation, which, in turn, could help break the cycle of addiction before the worst happens, just as the preventative medicine advocates drew it up. It turns out that the availability of addiction treatment facilities forms the dividing line between moral hazard and preventative medicine problems.

And that's where Ms Doleac and Ms Mukherjee and their critics in the medical community see eye to eye. Dr Faust, the emergency department physician, points out that the treatment goal "is to provide [opioid users] with both short- and long-term treatment options,"[2] which certainly means opening more treatment centers. Meanwhile, the study he's ostensibly criticizing concludes that "[i]ncreasing access to drug treatment, then, might be a necessary complement to naloxone access in curbing the opioid overdose epidemic." Either way, treatment infrastructure is the key to transforming opioid use into the kind of problem that physicians, not lawyers and judges, can solve. Opioid users are patients, not criminals, and doctor knows best.

References

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