

Medical Bankruptcy: Myth Versus Fact

This response to a widely cited paper by David Himmelstein and colleagues challenges the basis of its conclusions.

by **David Dranove and Michael L. Millenson**

ABSTRACT: David Himmelstein and colleagues recently contended that medical problems contribute to 54.5 percent of personal bankruptcies and threaten the solvency of solidly middle-class Americans. They propose comprehensive national health insurance as a solution. A reexamination of their data suggests that medical bills are a contributing factor in just 17 percent of personal bankruptcies and that those affected tend to have incomes closer to poverty level than to middle class. Moreover, for national health insurance to have an impact, it would have to define “medical” expenses in a much broader way than is now typical of either private or government-funded plans. [*Health Affairs* 25 (2006): w74–w83 (published online 28 February 2006; 10.1377/hlthaff.25.w74)]

The great enemy of the truth is very often not the lie—deliberate, contrived and dishonest—but the myth: persistent, persuasive and unrealistic.
—President John F. Kennedy, Commencement Address at Yale University, 11 June 1962.

IT IS NO SECRET THAT BAD HEALTH AND BAD DEBT often coincide. Unexpectedly large medical bills can impose a sizable burden on those who are already physically and economically fragile. In some cases, medical debt can contribute to a collapse of creditworthiness that forces some people to declare personal bankruptcy.

David Himmelstein and colleagues contend that this scenario is pervasive. “Medical problems contribute to about half of all bankruptcies,” they write.¹ They warn that “solidly middle-class Americans...face impoverishment following a serious illness,” and they propose a solution: comprehensive national health insurance such as that offered in Canada and Western Europe.

The authors’ research credentials and prestigious affiliations; the genuine human tragedy of illness and bankruptcy; and the attention given to their findings by the news media, policymakers, and researchers have helped make their conclu-

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sions “persistent and persuasive,” to use former President Kennedy’s formulation.² Unfortunately, a closer examination of their paper suggests three reasons why their conclusions are also unrealistic.

First, they fail to provide a causal relationship to support the claim that medical spending contributes to “half of all bankruptcies” (54.5 percent). Our analysis of their data finds a causal link in only 17 percent of personal bankruptcies. Nor do their data support their contention that “solidly middle-class Americans” are threatened. Four decades of studies that have explicitly addressed the bankruptcy–medical spending connection lend credibility to our conclusion. These studies, which we discuss below, support a much smaller figure than half, as does a more recent national consumer survey sponsored in part by the Harvard School of Public Health.³ As for the “solidly middle-class” citizens who face “impoverishment,” Himmelstein and colleagues report an average household income of \$25,000 for their respondents—a level more accurately characterized as “marginally middle class.”

Second, the authors’ methodology does not provide a definitive answer to the policy question they implicitly pose: how national health insurance would affect the rate of personal bankruptcy. At best, they show that medical bills are a cause of 17 percent of bankruptcies but are not necessarily the most important cause. They fail to perform the multivariate statistical analysis necessary to determine the magnitude of the causal relationship or to rule out other factors such as loss of job, education expenses, or housing costs. Indeed, an economic study cited by Himmelstein and colleagues concludes (in a portion they did not mention) that there is little support for the theory that households file for bankruptcy when “adverse events”—including health problems—reduce their ability to repay debts.⁴

Lastly, their suggestion that national health insurance would greatly reduce the number of bankruptcies linked to medical spending is misleading. They acknowledge that the impact would depend on the “comprehensiveness” of the plan. Our analysis shows that “comprehensiveness” in this context would require defining “medical” expenses in a way that is much broader than is now typical of either private or government-funded plans.

Background

Traditionally, many physicians charged little or nothing to treat those who possessed little or nothing. Hospitals continued the charitable tradition, albeit sometimes with a twist. In early-nineteenth-century America, poor patients were expected to begin working off their debt as soon as they were ambulatory. At New York’s Bellevue Hospital, for example, “expectant mothers...scrubbed floors within hours of delivery.”⁵

Modern health insurance originated during the Great Depression. As hospitals and physicians saw their income plummet, they began to accept the idea of reliable third-party payment through health insurance. Post–World War II advances in

medical technology and the expense of those advances prompted the public to clamor for reliable coverage. The result was widespread diffusion of health insurance as an employee benefit and the passage of Medicare for the elderly and Medicaid for the indigent.

Health insurance initially focused on catastrophic expenses. Over time, benefits increased, and consumer cost sharing shrank. Rising medical costs, coupled with recent increases in consumer cost sharing, are raising the anxiety level of the middle class. For example, for married-couple families with children, health spending rose three times faster than income between 2000 and 2003, absorbing half the growth of their income.⁶ The addition of a Medicare outpatient drug benefit on 1 January 2006 will lower out-of-pocket spending for the average senior; however, some elderly people, including some who are chronically ill, may find that sizable medication expenses continue to accumulate.⁷ Medicaid's budget woes are even more pronounced, as states restrict benefits or tighten eligibility requirements.

Private employers' spending on employee health benefits, meanwhile, jumped 51.4 percent from 1998 to 2003, to \$330.9 billion.⁸ As economic theory would predict, employers are responding by holding the line on salaries; real wages and salaries declined in 2004 by about 1 percent, while overall benefit expenses increased 3.5 percent.⁹ Employers are also requiring employees to make larger contributions to premiums and cutting back on the retiree medical coverage that has been a critical supplement to Medicare. As benefits costs have risen, the percentage of full- and part-time employees covered by and participating in employer-sponsored health insurance has declined, from 53 percent in 1999 to just 45 percent in 2003.¹⁰ Simultaneously, the hiring of new permanent employees appears to have slowed.¹¹

As a result of these trends, the potentially dire consequences of large medical bills is a topic of acute interest to millions of Americans. The two broad policy questions underlying Himmelstein and colleagues' paper are important: What is the impact of the rising consumer share of medical costs, and what changes to our health insurance system could alleviate the financial burden of medical care? However, the specific questions they addressed are narrower: To what extent do high medical bills precipitate personal bankruptcy, and to what extent is a Canadian-style health care system a likely solution to such a problem?

What Himmelstein And Colleagues Found

Himmelstein and colleagues surveyed 1,771 people who filed for personal bankruptcy in 2001. They also interviewed 332 debtor households (in part to put a human face on the problem), but these interviews did not contribute to the computation of the number of medical bankruptcies. Thus, we focus on the survey.

They summarized the responses in Exhibit 2 of their paper, which is organized in three sections. The first section reports the percentage of households who cited

one of the following as a specific reason for their personal bankruptcy: illness or injury; a birth or death in the family; and problems with alcohol, drugs, or gambling. This is the only part of their survey where one might infer a causal relationship between medical problems and bankruptcy. The most frequently cited reason for bankruptcy is illness or injury, cited by 28.3 percent of respondents.

The second section of Exhibit 2 reports the number of respondents who had a variety of medical-related problems, such as illness causing a loss of at least two weeks of income, and medical bills in excess of \$1,000 in the previous two years. The authors counted these as medical-related reasons for bankruptcy even if the respondents did not state that illness or injury was a reason for bankruptcy. They thus concluded that 54.5 percent of respondents had medical bankruptcies.

Criticisms Of Himmelstein And Colleagues' Analysis

Not long after the online publication of Himmelstein and colleagues' paper in February 2005, a conservative critique of it quickly appeared in *National Review Online*, while additional criticism and praise appeared in the eLetters section of *Health Affairs*.¹² Most of the criticism centered on the definition of *medical bankruptcy*, particularly the inclusion of people reporting medical bills exceeding \$1,000 over a two-year period. Critics say that many of these people might have paid their medical bills well before another event (such as the loss of a job) precipitated bankruptcy. Himmelstein and colleagues offered two responses. First, they noted that average medical bills for this group exceeded \$11,000, a figure that seems to show that outstanding medical bills were burdensome. However, the average of \$11,000 might have been influenced by a few outliers. For example, Leslie Conwell and Joel Cohen report that 20 percent of Americans spent more than \$3,200 on health care in 2002 but that just 5 percent spent more than \$11,500.¹³ Even so, the latter small group accounted for half of all U.S. expenditures. It would be more informative to know the median and other percentiles of the distribution of spending by the respondents to Himmelstein and colleagues' survey.

Second, Himmelstein and colleagues agree that some respondents might have paid off their medical debts, but they argue that without medical debts, respondents would have had more money available to pay other expenses. They also argue that the level of medical debt might have been understated, because some medical expenses might have been paid by credit card. The first argument could be made for all expenditures prior to bankruptcy, leading to the meaningless conclusion that all expenditures are responsible for all bankruptcies. The second argument merely reinforces the fact that since all debts are fungible, it is inappropriate to single out any one form of debt as the proximate cause of bankruptcy.

Data from the U.S. Census Bureau demonstrate the broader financial problems facing many lower-income Americans. In two years, a U.S. household with annual income of \$22,000–\$40,000 will spend an average of \$20,000 on housing, \$9,000 on food, \$8,000 on transportation, \$2,500 on clothing, and \$4,500 on health care.

This income level is comparable to the average income in Himmelstein and colleagues' sample and is most accurately characterized as "marginally middle class," rather than the authors' "solidly middle class" characterization. Census Bureau data show that a household annual income of \$25,000 is closer to the poverty level for a family of four (a little above \$18,000 in 2002) than to the median U.S. household income (about \$44,000 that year).

For most households in the \$22,000–\$40,000 income range, health care spending amounting to a few thousand dollars in the two years prior to bankruptcy would represent just the tip of the iceberg threatening to sink their creditworthiness. They have many other bills to pay. Moreover, it would be reasonable to budget for at least some health care expenses. Health care spending of a few thousand dollars might be unpredictable in its timing but not in its likelihood of occurring.

Moreover, although historical comparisons should be used cautiously, studies since the mid-1960s have consistently concluded that medical bills are a relatively minor part of the debt problem.¹⁴ More recently, a study in Cincinnati of bankruptcy filers seeking Legal Aid Society assistance in 2000–2001 found that 47 percent had "substantial" medical debt but that medical debt accounted for just 12 percent of their debt total.¹⁵

This past year, the U.S. Department of Justice (DOJ) responded to a request by Sen. Charles Grassley (R-IA) by examining 5,203 bankruptcy cases from the files of the U.S. Trustee Program. The filings occurred between 2000 and 2002, the same time frame as the filings studied by Himmelstein and colleagues. The DOJ reported that 90 percent of filers had medical debt of less than \$5,000. Of those reporting medical debts, those debts accounted for only 13 percent of total unsecured debt. The DOJ summarizes the evidence against Himmelstein and colleagues' thesis as follows: "The conclusion that almost 50 percent of consumer bankruptcies are 'medical related' requires a broad definition and generally is not substantiated by the official documents filed by debtors."

Taking these surveys under consideration, we observe that although medical costs have risen sharply over four decades, medical debt remains a small part of the overall burden of those filing for bankruptcy.

Refining The Research Methods

The debate over Himmelstein and colleagues' numbers should not obscure a deeper methodological issue. It is insufficient to show that medical problems are associated with bankruptcy; one must also determine whether, and to what extent, medical spending causes bankruptcies. That is, one must move beyond correlation to causation and magnitude. In an attempt to do so, we have reanalyzed the data used by Himmelstein and colleagues.

The only portion of their paper that addresses causality is the first part of Exhibit 2, which identifies people who stated that illness or injury was a cause of bankruptcy (although not necessarily the most important cause). If we seek to

learn the role of insurance in bankruptcies, we must identify those people who stated that illness or injury was a cause of bankruptcy and that medical bills contributed to bankruptcy. We call these “medical expenditure bankruptcies.”

According to Himmelstein and colleagues, 28.3 percent of respondents stated that illness or injury was a cause of bankruptcy. They also reported that medical bills contributed to the bankruptcy of 60 percent of this group. Multiplying the two figures together, we conclude that 17 percent of their sample had medical expenditure bankruptcies. Even for that 17 percent, we cannot state with any degree of certainty whether medical spending was the most important cause of bankruptcy. To move from causation to magnitude, one must perform multivariate statistical analysis on a sample of bankrupt and solvent individuals. The dependent variable would be a bankruptcy indicator. Predictors, in addition to those measured by Himmelstein and colleagues, would include economic and demographic variables such as employment and marital status. Only in this way could we make the kind of “all else equal” statements required to assess how medical debt affects bankruptcy rates. The authors fell well short of the mark. They neither interviewed a control population of solvent households nor collected economic control variables.

Several published studies of bankruptcy that did use multivariate analysis studies painted a different picture than the one depicted by Himmelstein and colleagues. We summarize key research below.

■ **Congressional Budget Office.** The Congressional Budget Office (CBO) analyzed the 75 percent increase in personal bankruptcy filings between 1994 and 1998 by reviewing the “voluminous” literature on personal bankruptcy in a 2000 report.¹⁶ By all accounts, the period under review was one of flat to expanding health insurance coverage. The total health benefit cost per active employee rose less than 5 percent, and the cost of health benefits for active and retired workers actually declined in 1994 for the first time in memory.¹⁷ The fact that bankruptcy rates nonetheless rose sharply suggests that something besides medical factors was to blame.

The CBO review cites many factors that contribute to bankruptcy, including large medical bills, divorce, loss of income as a result of unemployment, and poor debt management. Legislative changes making it easier for people to recover from bankruptcy may also have been a factor. Even so, the CBO reports that “researchers have made little progress in judging the *relative importance* of the factors that lead people to file” (emphasis added).

■ **Fay, Hurst, and White.** A 2002 study by Scott Fay, Erik Hurst, and Michelle White in *American Economic Review* is the only paper in an economics or finance journal to be cited by Himmelstein and colleagues, who refer only to an observation by Fay and colleagues about survey data.¹⁸ A more thorough reading of the Fay paper, however, reveals several findings that are at odds with Himmelstein and colleagues’ conclusions. Using data from a 1996 panel survey that included information about household bankruptcy filings, Fay and colleagues employed multivariate probit re-

gression to determine the contributing factors. Among those factors were whether the household head or spouse experienced health problems in the previous year. Controlling for debt levels, Fay and colleagues found no statistical link between bankruptcies and health problems. This finding is consistent with the idea that medical debt is like any other debt—a cause but not the most important cause of bankruptcy. They conclude that bankruptcy is the response to an accumulation of debt, not to one particular factor such as a health problem.

Data from the 2005 Commonwealth Fund biennial health survey support this conclusion. The survey found that 41 percent of adults ages 19–64 had a high rate of medical bill problems or incurred medical debt. Sixty-two percent of these nonelderly adults had insurance when the problem occurred. Yet although a sizable minority of these adults put off filling a prescription or going to the doctor, only one in ten of those who were insured all year said they had to “change [their] way of life to pay medical bills.” Even for those who were uninsured for some period during the year, only 28 percent reported a lifestyle change.¹⁹

These two studies confirm the basic economic concept that all liabilities are fungible. No one category of liability is more likely than others to dictate a lifestyle change or even crossing over the brink into bankruptcy.

■ **Domowitz and Sartain.** A 1999 study by Ian Domowitz and Robert Sartain in the *Journal of Finance* examined 827 households who filed for bankruptcy in 1980 matched against 1,862 households not in bankruptcy.²⁰ Domowitz and Sartain performed multivariate nested logit regression to isolate the specific causes of bankruptcy. They first reported that “high medical debt (in excess of two percent of income) has the greatest single impact of any household condition variables in raising the conditional probability of bankruptcy.” They tempered this finding with two further observations: First, only a tiny percentage of the population had high medical debt. Second, medical problems might be correlated with employment disruptions; if the latter contribute to bankruptcy, the coefficient on medical debt is biased upward. Accounting for prevalence of various sources of debt, Domowitz and Sartain found that “the largest single contribution to bankruptcy at the margin is credit card debt.”

Other data on credit card payments support our previous contention that those with trouble paying all of their bills, not just medical expenses, are most vulnerable to bankruptcy. A recent Federal Reserve Board survey found an overall 1.1 percentage point decline from 1998 to 2001 in the proportion of debtors who were sixty or more days late with their payments on any of their loans in the preceding year, but an increase of 1.6 percentage points in late payment for families whose net worth was in the lowest 25 percent of the distribution.²¹

■ **Gross and Souleles.** A 2002 study by David Gross and Nicholas Souleles in the *Review of Financial Studies* is the first, to our knowledge, that uses a methodology that could directly determine the effect of insurance status on personal bankruptcy.²² Gross and Souleles used multivariate regression to predict personal bank-

ruptcies, with one of their predictors being health insurance coverage. Although the study used individual-level bankruptcy data, its measure of insurance was at the state level. This leads to two potential biases. First, state-level insurance coverage is a “noisy” measure of each person’s insurance status. This might reduce the measured impact of insurance. Second, interstate variation in insurance coverage might be correlated with unmeasured variation in the social safety net. This would increase the measured impact of insurance. Overall, it is difficult to draw firm conclusions from Gross and Souleles’ analysis.

There is one methodological problem that occurs in all the papers cited above, including that of Himmelstein and colleagues. They all fail to address the problem of reverse causality—that is, whether medical spending causes bankruptcy or whether financial turmoil causes medical problems (for example, because of stress). The resulting endogeneity bias will therefore overstate the extent to which medical bills cause bankruptcy.

Policy Implications

The paper by Himmelstein and colleagues was intended to go beyond the generalization that personal bankruptcy represents a human tragedy and address specific questions: To what extent do high medical bills precipitate bankruptcy filings in the middle class, and to what extent is a Canadian-style health care system a likely solution? It is precisely in regard to these policy issues that the paper too often leaves fact behind and creates unrealistic myth.

The authors suggest the “low rate of medical bankruptcy in Canada” is to the credit of its health care system. The only source given for the rate is a *Texas Law Review* article attributing 7.1–14.3 percent of Canadian bankruptcies to “health/misfortune.”²³ More broadly, their support for a Canadian model assumes a robust link between medical costs and bankruptcy that numerous econometric studies show is unjustified. Indeed, research specifically analyzing soaring bankruptcy rates in both countries attributed the increased filings primarily to easier access to credit through “financial liberalization.”²⁴

The role of easy credit was explicitly acknowledged by one of Himmelstein’s co-authors (Elizabeth Warren) in a 2000 interview: “Today families are carrying so much more consumer debt that even a modest medical bill can put them over the edge financially.”²⁵ Given that reality, the press-release prescription from Physicians for a National Health Plan, a group cofounded by Himmelstein and his coauthor Steffie Woolhandler, is difficult to justify. It says the Himmelstein and colleagues paper shows that “only national health insurance can solve the problem.”

In their *Health Affairs* paper, Himmelstein and colleagues acknowledged that the impact of national health insurance would hinge on its being “much more comprehensive than many current policies.” They do not delve into detail, but a 2004 study of women’s expenses after being diagnosed with breast cancer illustrates just how comprehensive this national coverage would have to be. The study found

that mean monthly direct medical costs of insured women undergoing cancer therapy were \$597, or 41 percent of the \$1,455 monthly total costs of the disease.²⁶ This includes \$134 for miscellaneous expenses (such as speech therapy) and “supplies” (such as lotions and laxatives). Direct nonmedical costs were \$131 (for child care and the like), while indirect costs were \$727, including time lost from work by the patient and family members. In other words, miscellaneous medical and nonmedical costs accounted for two-thirds of the monthly financial burden of this one cancer. To limit that economic impact, national health insurance would have to be far more comprehensive than any current single-payer system is.

Himmelstein and colleagues omit any reference to personal choices, such as taking on debt, even in their household interviews. In this they act more like good doctors than good economists or policymakers. For although it is good medical practice to work as hard to save the life of a careless drunk driver as a sober careful one, it is equally good economics and public policy to penalize the careless driver with higher insurance rates and possible criminal prosecution.

Finally, any form of national health insurance must be paid for. As economist Victor Fuchs points out, that process creates winners and losers whose identity might not be obvious. He writes:

The ultimate cost falls on families and individuals, even when the payment mechanism makes it appear the bill is being sent elsewhere.... No magic wand of finance can divert labor, capital and other resources to medical care without resulting in a reduction in resources available for food, housing, education, recreation, or other goods and services.... The average family will have to pay the same share under any system.²⁷

Put differently, weaving a medical-cost safety net that could protect virtually every person from bad behavior or bad luck might actually poke holes in the safety net for other vulnerable citizens. Good intentions are not enough. The Book of Job, far older than the Roman laws cited by Himmelstein and colleagues, teaches the hard lesson that no amount of good fortune is irreversible. Some combination of illness, job loss, and personal problems can assuredly dislodge even the most firmly rooted member of the middle class.

Unfortunately, expansive proposals to protect all of us distract from the pressing need to protect some of us, such as the forty-five million Americans with no health insurance and millions of others who are underinsured and vulnerable. “First, do no harm” is not just good advice for physicians; it should apply to those who would make health policy as well.

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The authors are grateful to America's Health Insurance Plans for supporting this research.

NOTES

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