Financial Crisis in American Households

The Basic Expenses That Bankrupt the Middle Class

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CHAPTER SIX

Necessary "Necessities"?

Critics might argue that much of this "essential" spending is not really necessary. One might maintain that homes are growing more luxurious, colleges seem to resemble deluxe resorts, and a lot of healthcare is servicing people's hypochondria and their inability to accept mortality. Without denying that some basic levels of healthcare, education, or housing are undeniably important to people's well-being, one could argue that at least some—if not much—of these expenses are more reminiscent of the hedonism, status jockeying, vanity, and other base motives typically ascribed to household spending by those who subscribe to the "culture of consumerism" perspective. So how much of this spending is really necessary, and how much is dressed-up consumerism?

While there are almost certainly many examples of wasteful "essential" spending, stories about McMansions, private colleges, or unnecessary medical procedures obscure the fact that the costs of basic products are rising. Health insurance costs are the key driver of healthcare spending, there are strong rationales for arguing that everyone should have health insurance, and (at least until the Affordable Care Act [ACA]) quality basic health insurance was highly unaffordable. The vast majority of college-bound Americans go to public colleges and universities, whose admissions costs are increasingly hard to distinguish from their private counterparts. Housing costs are mainly driven by location, and, in the United States, your place of residence determines your access to schools, jobs, infrastructure, distance from social and environment problems, and a range of other nontrivial opportunities and amenities.

Many of these pressures have mounted in a broader context in which economic policy-makers have increasingly embraced neoliberal reforms.

Until recently, government had done very little to contain the spiraling cost of health insurance, and even its comparatively modest efforts to do so under Obamacare have attracted massive, sustained opposition. The burden of higher education has risen while government subsidies for public schools have fallen. The pressure to gain a foothold in a "good neighborhood" developed during a period in which policy-makers largely eschewed economic redistribution and sought to transfer responsibilities for public services down to local-level governments. Rather than taking a proactive role in containing the cost of these essentials—as is done in other developed countries—the United States relied on the "invisible hand" to contain costs, and the scheme failed.

One nagging question in this line of argumentation involves questions about the degree to which all of this "essential" spending is really essential. Although there is little doubt that some level of education, healthcare, and housing is essential to maintaining basic well-being, there comes a point past which spending on these "basics" is excessive. Purchasing a backyard pool or big screen TV also registers as housing expenditures in the data. Plastic surgery or tuition at a swanky private school count as healthcare and education costs, respectively. These are more obviously problematic miscategorizations of nonessentials as basic needs. However, what about people's sense that they need to send their children to good schools or cover their children's costs of college? What about their need to live closer to work or in a pricier area such as New York or San Francisco because the "good" jobs are there? What about their need for a pricey health insurance plan because their preferred doctor doesn't accept the cheaper ones? The line between what is necessary and what is optional can get fuzzy.

This is one of the more complicated issues facing the development of this argument, and we touched on similar issues in Chapter Three. To make some determination about a product's "essentiality," we must develop some definition about what people need or do not need, and our choices will influence our findings. An expansive definition of people's needs pushes an analysis to see more deprivation because fewer people are going to meet our high standards for an acceptable quality of life. Conversely, if we restrict our definition of a basic livelihood to bare minimums—food, shelter, and a library card—then our analysis will be more disposed to see deprivation rarer. The necessity of these types of costs are debatable, and arguments about what constitutes a need or a want can go on interminably. At some point, we need to develop some set of reasonable criteria that can allow our discussion to proceed.

There are many criteria by which to gauge people's quality of life, and thus many criteria by which to judge the true necessity of these "essentials."[1]

One way to make such a determination is to develop a sense of the degree to which the acquisition of a product has a likely impact on people's health, safety, and capacity to find gainful work. This third criterion—influence over a personal's capacity to find gainful work—is important because the ability to work provides people with a basis for earning money, living with independence and autonomy, and covering the costs of other basic products. To the extent that education, healthcare, and housing expenditures help people secure their health, safety, and capacity to work, then they are deemed to be essential. To the extent that such expenditures do not appreciably affect someone's health, safety, or basic employability, they are taken to be nonessential.

Explanations of Rising Prices

If society is to engage the rising cost of these basic products, it should consider why out-of-pocket costs are spiraling upward. Our explanations influence our interpretation of the problems and solutions that drive up spending.

Two generic explanations of rising costs are that they are a by-product of rising living standards, which we might term the "quality" and "quantity" explanations. The *quality* argument maintains that costs have risen because products are better, which presumably cost more to make, and these increased costs are passed on to consumers. For example, high pharmaceutical costs are often attributed to high research and development costs, we pay more for drugs to cover these costs, but these increased costs are covering drugs that are better. The *quantity* argument maintains that costs have risen because people purchase more. People spend more in healthcare and education because they purchase quantitatively more education and healthcare. Housing is more expensive because people are said to be buying bigger homes with more appliances and amenities. Both quality and quantity explanations of rising costs suggest a situation in which the costs of essentials are rising because our living standards are rising. We are spending more because we are getting better stuff and/or more of it.

A third argument—*profit taking*—maintains that living costs are being driven up by suppliers who take bigger markups on the sale of essentials. People are paying more, and the increased cost goes to those who work for, do business with, or invest in these industries. Unlike the previous two arguments, this scenario does not imply that the public is benefiting from the broader process that drives up the cost of necessities. Instead, it represents a failure of the market system, which allows people to profit at the expense of society at large. Under these circumstances, a society might

question the benefit of leaving product markets in the hands of unfettered markets, as opposed to regulating them, socializing them, or fielding government alternatives to compete with the private sector.

This kind of profit taking may be facilitated by the privatization of the delivery of these essentials. *Privatization* is used here in the sense of converting a publicly owned or publicly administered operation or enterprise into a private, nongovernmental one. It can happen when, for example, a government goes from taking responsibility for delivering higher education or healthcare to one in which private markets are left to deliver these services. The government may continue to fund the enterprise but not administer it—for example, when it goes from directly running prisons to a system in which businesses are subcontracted to run them. Alternatively, it can simply stop funding or delivering services, for example, by simply shuttering public health mental treatment centers, and leaving families or the criminal justice system to deal with the mentally ill. High out-of-pocket prices are the result of governments' failure to subsidize, directly deliver, or price-regulate these products. The businesses who fill the void left by government upcharge the rest of society. In essence, such a view frames the rising cost of necessities as a result of neoliberalism and the market mechanism's failure to deliver a bounty of cheap, high-quality essentials. This perspective may see privatization as enabling unproductive profit taking.

Healthcare

In Chapter Five, we saw that healthcare expenditures rose by nearly 80 percent between 1980 and recent years. This rise has been substantially driven by rising prices; healthcare inflation has nearly doubled the rise in both general prices and incomes. Under normal circumstances, healthcare tends to be a minor budgetary item for most households. Healthcare costs materialize as shocks, which households experience as extraordinary and unpredictable. However, these shocks are quite common and widespread. Although relatively fewer households are hit with major medical expenses in any given year, the chances of a given household experiencing one or more such shocks over their lifetime is reasonably good.

Insurance Is the Fastest Rising Healthcare Expenditure

The primary driver of rising healthcare spending is rising expenditures on insurance. Table 6.1 compares healthcare spending in 1996 and 2014.[2] The table gives an overview of median total spending relative to posttax income, the proportion of households that spend money on major subcategories

Table 6.1 Healthcare Spending by Households (% Disposable Income), 1996 versus 2014

	1996	2014	Change
Total Spending			
Median Spending	1.72%	2.53%	+47%
Percent Spending over 5%	25%	32%	+28%
Percent Spending over 10%	13%	17%	+31%
Percent Spending over 25%	5%	7%	+40%
Health Insurance			
Percent Any Outlays	62%	69%	+11%
Median Outlays	1.3%	2.0%	+52%
90th Percentile Outlays	7.0%	11.6%	+67%
95th Percentile Outlays	20.8%	33.3%	+60%
Medical Services			
Percent Any Outlays	48%	42%	–13%
Median Outlays	0.5%	0.5%	–12%
90th Percentile Outlays	4.6%	4.3%	–7%
95th Percentile Outlays	10.5%	10.0%	–5%
Drugs			
Percent Any Outlays	46%	42%	–9%
Median Outlays	0.3%	0.3%	+7%
90th Percentile Outlays	3.2%	2.9%	–11%
95th Percentile Outlays	6.9%	6.8%	–1%
Medical Supplies			
Percent Any Outlays	12%	10%	–17%
Median Outlays	0.4%	0.4%	–19%
90th Percentile Outlays	2.5%	2.5%	+2%
95th Percentile Outlays	4.7%	6.5%	+38%

Source: Bureau of Labor Statistics (2015).

of healthcare expenditures, and the incidence of high expenditures (relative to incomes) overall and across major subcategories.

The typical household does not spend a lot on healthcare from year to year. Spending at the median is low in proportion to disposable incomes, at about 2.5 percent of take-home pay. Costs can rise quickly when a household is afflicted by a medical event (e.g., an injury or illness) or temporarily

loses coverage (e.g., someone loses a job with insurance). In 1996, about one-quarter of U.S. households spent more than 5 percent of their disposable income (about 2.5 weeks of annual income) on healthcare, compared to one-third by 2015. The proportion spending more than 10 percent (or just over one month's net pay) rose from 13 percent to 17 percent, and those spending over 25 percent rose from 5 percent to 7 percent.

The table shows that health insurance has been the primary driver of these increased expenditures. Other types of expenditures have generally declined, both in terms of the percentage of households incurring any costs and the outlays of households that spend comparatively more on these products. Insurance has been the focus of discussions about healthcare for several years now, in no small part because it is the most obvious cost and in part because it was the focus of politically charged reforms under the ACA. Often, popular explanations of rising insurance costs focus on two appealingly simple explanations: insurance company or employer profiteering. Both probably draw attention away from the core drivers of rising healthcare costs.

One problem with insurance company profiteering explanations is the fact that these companies do not seem to be particularly profitable. Table 6.2 shows estimates of the profit margins taken in by the health insurance industry, along with other major healthcare industries and other major economic sectors.[3] Here, *profit margin* is the ratio of profit to sales—how much profit is made on every dollar of sold goods or services. The "Healthcare Plan" industry, including many of the country's largest publicly traded health insurance companies, registered relatively low profit margins in comparison to other healthcare industries or major economic sectors.

Although profits fluctuate from year to year and among companies within the same industry, the profit margins in 2015 appear to be quite typical. While health insurance may not be highly profitable relative to other healthcare subsectors, in the next chapter, we will see it is very expensive compared to other countries' health insurance and delivery systems. The private health insurance sector consumes more resources than public systems such as Medicare or foreign countries' highly regulated and/or socialized insurance systems. For example, a 2011 study found that the average U.S. physician spent $82,975 per year dealing with private insurers, just under 4 times the cost borne by Canadian physicians in their single-payer system ($22,205).[4] The time demands of negotiating this system were 10 times that borne by Canadians.[5] Insurance companies may be part of the problem, but it seems unlikely that the rising burden of healthcare can be fully reduced to insurance company salaries and profits.

A second commonly heard argument maintains that employers have capitalized on the tumult of healthcare reform to cut employee health

Table 6.2 Profit Margins in the Healthcare Industry, Publicly Traded Companies, 2015

Sectors/*Industry*	Market Capitalization (Billions)	Profit Margin
Drug Manufacturers—Major	50,131	21.4
Biotechnology	16,616	19.7
Drug Manufacturers—Other	252	18.5
Technology	*180,488*	*17.7*
Financial	*97,685,646*	*17.6*
Healthcare	*83,019*	*17.2*
Diagnostic Substances	15	11.7
Medical Instruments and Supplies	413	11.4
Medical Appliances and Equipment	3,601	10.6
Utilities	*32,370*	*9.9*
Drug Delivery	256	8.3
Consumer Goods	*249,515*	*7.7*
Medical Laboratories and Research	378	6.7
Services	*93,968*	*6.4*
Specialized Health Services	80	6.2
Industrial Goods	*56,515*	*4.8*
Hospitals	1,039	4.3
Healthcare Plans	2,569	3.2
Home Healthcare	11	2.6
Basic Materials	*332,353*	*1.9*
Drug-Related Products	21	–1.2
Conglomerates	*1,728*	*–2.3*
Long-Term Care Facilities	49	–2.9
Drugs—Generic	7,582	–4.8

Source: Yahoo! (2016).

insurance benefits. There is reason to believe that, over time, slightly fewer employers offer health insurance and that employers have been transitioning to insurance plans with higher co-pays, higher deductibles, or narrower coverage. This argument ignores the fact that insurance costs have been spiraling for employers as well. While larger firms have generally maintained coverage for their employees, smaller employers have steadily cut

employee coverage since 2000.[6] In 2000, 68 percent of employers with fewer than 200 workers offered coverage, and 57 percent of those with fewer than 10 workers offered coverage. By 2015, these numbers fell to 56 percent and 47 percent, respectively. During that time, the cost of insurance premiums has nearly tripled. Larger employers (more than 200 workers) have overwhelmingly maintained employee coverage. All of this suggests that employers have generally maintained coverage and done so while employer payments for insurance have also been rising. Rising insurance costs are not clearly the result of employer cutbacks.

What seems more likely is that insurance premiums are rising mainly because payouts are rising, and payouts are rising because everyone is either consuming more or charging more. As Table 6.2 demonstrates, the healthcare sector is replete with highly profitable noninsurance businesses. Drug manufacturers and biotechnology firms do tremendous volume at very high markups, and many drug-related expenses are going to be channeled through hospital bills, doctor bills, and insurance premiums. Diagnostic equipment, supplies, and services are sold at much higher markups than most consumer goods and services, which also helps to drive up hospital, doctor, and insurance costs.

In sum, there appears to be a very broad-based rise in healthcare expenditures. The pressures of these expenditures are experienced by households in the form of faster-rising health insurance premium, cuts in the degree to which employer-sponsored health insurance absorbs medical costs, and perhaps some disappearance of jobs that offer health insurance. All of these pressures appear to be a result of a broader-based rise in healthcare costs across the entire sector, which affects households, employers, and insurance companies. In other words, the burden of healthcare spending is growing everywhere.

More and Better Healthcare (to Some Extent)

So expenses are widely rising across the healthcare sector. What is driving up these outlays? Are Americans consuming quantitatively more or better healthcare, or is the healthcare industry profiting at the expense of society at large?

We have some indication that the quality of healthcare is increasing. Perhaps the most basic metric of healthcare system performance is life expectancy, which has risen by roughly 12.5 years for men (a 20 percent rise) and 4 years (+5 percent) for women since 1970. Not all of this change can be attributed to medical care; for example, better safety conditions, healthier work environments, and declines in unhealthy behaviors (e.g.,

smoking) play an important role in lengthening lives (substantial reasons that men's life spans have lengthened so much). Estimates of the direct role of medical care are not abundant, but some analyses suggest that between one and two years of this rise come from medical advancements.[7] Improved healthcare can claim some credit for these improved outcomes in detection and survival rates for a wide range of diseases—from cancer to heart disease to diabetes—but successful public health and safety campaigns deserve a great deal of credit as well.[8]

There is some indication that people utilize more healthcare, but the overall record gives a mixed picture. For example, prescription drug use has risen. Between 1999 and 2012, the proportion of Americans taking prescription drugs rose from 51 percent to 59 percent, and the proportion taking five or more prescriptions rose from about 8 percent to 15 percent.[9] In other respects, usage has been stable or fallen. Rates of hospital use were relatively stable during the 1990s and 2000s (though lengths of stay shortened), but this rate has been declining since 2010.[10] Outpatient doctor visits did not rise considerably either.[11] Some areas and periods witnessed increases in the use of healthcare, and there are indications of decreased utilization as well. Moreover, any discernible growth is very modest in comparison to the rate at which outlays have grown.

Profit Taking

Although it is possible that improved quality and more utilization pushes up society-wide healthcare spending, other highly developed countries have experienced similar changes, but their healthcare costs are nowhere near as high as in the United States. For example, the French healthcare system has also had to bear the burden of financing investment in MRI machines, but an MRI diagnosis in France costs roughly a quarter of what it costs in the United States.[12] Price are high in the United States, despite the fact that MRIs are more abundant there (see the next chapter).

Many observers believe that healthcare costs are driven mostly by massive profit taking. In his widely acclaimed investigative report, *Time* journalist Stephen Brill found that hospitals charge huge markups on privately insured, and especially uninsured, procedures. These markups can be on the order of hundreds of times cost, even for commonplace low-tech items such as aspirin or latex gloves. Likewise, pharmaceuticals are very expensive in the United States in part because, unlike Canada, for example, governments do not wrest price concessions from pharma companies. These high prices are often justified on the grounds that drugs are expensive to develop, though critics often argue that these R&D costs are exaggerated

and that drug companies spend more on marketing than research.[13] Doctors also fare quite well. According to the Bureau of Labor Statistics, the average general practitioner earns $192,120.[14] Reports maintain that average specialist salaries range from $158,597 for medical geneticists to $609,639 for neurosurgeons.[15] In comparison, the average British general practitioner earns the equivalent of $81,139 and, among all British specialists, the average salary is $146,741. Million-dollar hospital administrators are much less common abroad.

Money Wasted or Well-Spent?

Very few would argue with the notion that some basic level of healthcare is essential to people's well-being and is therefore a necessary investment. There is much room to debate how much medical care is necessary and where to draw the line between necessary and unnecessary healthcare. Perhaps the only kind of care that is firmly treated as essential in the United States is the provision of emergency care, which hospitals are legally mandated to provide. Health insurance for the elderly is also treated as essential, and the United States provides a federal system of socialized insurance for older Americans with Medicare. In conjunction with its states, the country has a patchwork of programs designed to provide health insurance to children through the Children's Health Insurance Program (CHIP) and to the poor through the Medicaid program. However, insurance for the working-age population is widely treated as optional, and a sizable part of the population are left uninsured (about 17 percent in 2013, half of whom said they did not have insurance because it is too expensive[16]).

Is not having insurance such a big problem? Although people will not necessarily die young without the perquisites of (quality) insurance—such as preventative healthcare or costlier therapeutic services—many studies suggest that life expectancy is lower among the uninsured.[17] Without insurance, people are exposed to the risks of not having access to proper therapeutic or preventative care. They are also exposed to potentially crippling debts if they experience an adverse medical event. Many other highly developed countries treat insurance as a necessity. Most healthcare spending is driven by insurance costs, and it seems quite reasonable to consider insurance a necessity, because it both affects access to healthcare and protects a household's finances from the shock of adverse medical events.

This is not to imply that no waste is involved. Many observers argue that Americans consume too much medical diagnosis and treatment. They maintain that Americans overuse healthcare,[18] and much of their spending is incurred in their last year of life[19] (implying that people are being kept

alive artificially[20]). Without dismissing these very important questions, the fact remains that the U.S. healthcare system is very expensive. Far more is spent on the system than its resources, technology, availability, and success warrants. As we will see in the next chapter, both the private and public cost of U.S. medicine is far higher than any other highly developed country, and yet the system is decidedly typical, and in some respects lacking, compared to the systems of other rich countries. It seems a perversion to ask whether or not we should let people die earlier or deny them diagnostics and treatments that some (nontreating physicians) view as unnecessary *before* asking whether or not we should tackle what seems to be unproductive profit taking. A lot of healthcare spending may be unnecessary, but the spending is not being driven by consumer largesse. Instead, the drivers of these costs appear to be captured by this industry's suppliers in high costs.

Education

Primary and secondary education (kindergarten through 12th grade [K–12]) is fully socialized and universally accessible in the United States, but child care, preschool, and postsecondary training are not, and their out-of-pocket costs can be substantial. Although not all households incur these kinds of costs, those with children often face heavy costs for some part of their financial life cycles. These costs may be temporary, but they may have lasting consequences. There are clear rationales for treating both expenses as necessary, but there are also questions about whether people overspend on these things.

Child Care

In the United States, child care is widely considered to be a household service, akin to housekeeping or yard work—a household chore that parents pay someone else to complete. In many other highly developed societies, early childhood care is seen as a formative, educational endeavor, and societies create institutions to care and educate the very young in the same way that the United States does for its K–12 students. Education-oriented, institutionalized care is more strictly the province of wealthier parents in the United States compared to many other developed societies, although there are nascent—and very modest—efforts to expand publicly provided child care.

There are several reasons to see child care as a nontrivial service. Insofar as children are concerned, high-quality child care—center-based care with more and better-trained staff, higher-quality amenities, and more

stringent structure and supervision—is thought to substantively impact young children's scholastic performance, behavioral skills, and social skills.[21] Perhaps more importantly, child care can play a critical role in allowing parents to work and earn money. The United States does not have system of mandated, funded parental leave or child care, and—as we saw in Chapter Two—many families lack the accumulated wealth or high incomes to sustain years of lost income involved in having a parent care for a child until the child is eligible for primary school. Single parents don't even have the option. Many families—especially young ones—rely on two incomes to sustain a livelihood. Single-adult households are much more vulnerable to poverty in no small part because they only have one income. Child care enables people to work.

At present, policy expands access to child care through income tax reductions and more local initiatives.[22] Tax reduction generally does not benefit lower-income households substantially because payroll taxes—not income taxes—are the mechanism by which their incomes are taxed. Moreover, the savings generated by these mechanisms are generally paltry relative to the costs of this care. Public child care aid is most forthcoming to the very poor, but more limited to families whose parents work but receive lower incomes. Studies suggests that poorer people are priced out of professionalized, center-based child care, and thus they generally receive poorer child care than their wealthier counterparts.[23] This low prioritization has left the provision of child care to be financed more exclusively by parents, and it can be expensive. According to U.S. Department of Education estimates, it costs an average of $12,401 to provide schooling for the country's average primary or secondary student.[24] Parents don't see this final bill because the cost is socialized. Child care costs, which are not socialized, are roughly similar.

Table 6.3 shows the 10 high- and low-cost child care states, along with a middle-cost state (Iowa).[25] It depicts the annual costs of infant and four-year-old care, both in terms of absolute costs and in relation to the states' median wages for single- and married-parent families. The table is sorted by the cost of infant care relative to median single-parent household income. The table shows how the cost of institutional child care can be staggering, especially for single-parent families. In 2015, market rates in the 10 most expensive states amounted to half or more of the median single-parent household income. Even married couples would have to bear considerable costs of about 15 percent of their household income. The cost of care for preschool children can be just as high. These costs are even more staggering when we consider the fact that younger parents tend to have young children,

Table 6.3 Cost of Child Care in Selected States, 2015

Rank	State	Infant Care	% Single Income	% Married Income	Four-Year-Old Care	% Single Income	% Married Income
1	District of Columbia	$22,631	88.5%	14.4%	$17,842	69.7%	11.3%
2	Massachusetts	$17,062	62.8%	15.1%	$12,781	47.1%	11.3%
3	New York	$14,144	54.5%	15.2%	$11,700	45.1%	12.6%
4	Illinois	$12,964	54.0%	14.7%	$9,567	39.8%	10.8%
5	Minnesota	$14,366	53.6%	15.2%	$11,119	41.5%	11.8%
6	Oregon	$11,322	50.7%	15.2%	$8,767	39.3%	11.8%
7	Rhode Island	$12,867	49.2%	13.3%	$10,040	38.4%	10.4%
8	Wisconsin	$11,579	48.9%	13.7%	$9,469	40.0%	11.2%
9	Michigan	$9,882	48.6%	12.2%	$6,764	33.2%	8.3%
10	Kansas	$11,201	46.9%	14.1%	$7,951	33.3%	10.0%
25	Iowa	$9,485	39.4%	11.6%	$8,216	34.1%	10.1%
41	Nebraska	$7,926	32.7%	9.9%	$6,843	28.2%	8.6%
42	Utah	$8,641	32.3%	11.7%	$6,612	24.7%	8.9%
43	Arkansas	$5,995	32.1%	9.2%	$4,995	26.7%	7.7%
44	South Carolina	$6,475	31.9%	8.8%	$4,651	22.9%	6.3%
45	Alabama	$5,637	30.5%	7.7%	$4,871	26.3%	6.6%
46	Hawaii	$8,280	29.9%	9.5%	$9,312	33.6%	10.6%
47	Louisiana	$5,747	29.8%	6.9%	$4,914	25.5%	5.9%
48	Tennessee	$5,857	29.3%	8.2%	$4,515	22.6%	6.3%
49	Wyoming	$6,541	27.9%	7.8%	$5,833	24.9%	6.9%
50	Mississippi	$4,822	26.3%	7.1%	$3,997	21.8%	5.9%
51	South Dakota	$5,661	24.1%	7.3%	$4,804	20.5%	6.2%

Source: Child Care Aware (2015).

and their incomes are more likely to be below median than a household headed by middle-aged people.

Child care is clearly not a frivolity and can be critical to a family's ability to earn money. Without systems to help give parents the financial leeway to parent their own children, they are often pressed into a market where the out-of-pocket costs can be considerable. Of course, there are other alternatives. If they have enough money to hire their own nannies, parents often resort to the "black market" for child care and often while breaking tax laws that mandate the payment of payroll taxes. Some are able to rely on family members to provide free care, and there are programs to help poor families with the costs of child care. For those who cannot or do not want to avail of these options, they are left with staggering costs, which are commensurate with the purchase of a new car or an additional apartment.

Higher Education

The economic benefits of higher education are quite clear. As we saw in Chapter Two, more educated people tend to earn more and accumulate more wealth. They are also less likely to be unemployed and poor.[26] Educated people generally fare well in a range of well-being metrics: they live longer,[27] they are less obese,[28] their marriages last longer,[29] and some studies suggest they have higher levels of subjective well-being.[30] The list could go on. The main point is that there are many reasons to believe that higher education has a substantial positive impact on people's well-being. Moreover, as we noted in Chapter Four, higher-skilled laborers are probably not under as much pressure from foreign competition and automation as their low-skill counterparts, making education important to a households' (and perhaps larger workforce's) long-term economic viability.

Given these implied benefits, it should come as no surprise that more Americans are pursuing a postsecondary education. The proportion of Americans aged 25 to 34 with a college degree rose from 24 percent in 1980 to 35 percent in 2014.[31] This change was driven by a dramatic rise in college attainment by women, alongside a much more modest rise in male attainment. The proportion of people in this age range who completed some college or an associate's degree rose from 20 percent to 28 percent. More people are pursuing higher education; that is, they are consuming (or investing in) quantitatively more higher education.

The cost of education has also been rising. Since 1980, college tuition has more than tripled in cost, becoming far more expensive relative to stagnant household incomes.[32] In part, these rising prices are fueled by rising costs incurred by schools. At public four-year colleges, spending on student

services rose by about 45 percent from 1990 to 2008, instructional support by 34 percent, academic support by 33 percent, and instruction itself by 19 percent.[33] Universities do not appear to be hiring considerably more employees, and in some respects they have been transitioning away from more expensive full-time teaching staff to cheaper, part-time instructors.[34] Along with increasing numbers of part-time instructors, colleges seem to be channeling more resources to noninstructional professional staff (the types that work in areas such as information technology, admissions, human resources, athletics, and student health).[35] According to Robert Hiltonsmith of the think tank Demos, healthcare coverage for these employees has played an important role in driving up the cost of employees.[36] Many analysts (including Hiltonsmith) maintain that the primary driver of rising out-of-pocket tuition costs is reduced state funding for higher education. Over recent decades, public funding for higher education has transitioned away from the direct subsidy and control of tuition costs to one that focuses more on subsidizing student loans.[37] An estimated 80 percent of rising tuition costs are attributed to falling state subsidies.[38]

The consequences of expensive higher education are wide-ranging. Children from high-income families are six times more likely to graduate college than those of low-income families.[39] Research suggests that student debt can depress graduation rates, damage postcollege financial health, and press students to forgo college to avoid debt or enroll in junior or nonselective colleges when they could otherwise qualify for four-year or more selective ones.[40] Moreover, heavy student debts may ultimately damage young people's long-term wealth accumulation. Student debt makes it more difficult to put together an emergency fund, save for retirement, or put money aside for a home down payment.

What about education at a high-price, prestigious institution? Many media stories lamenting the burden of student debt feature someone who graduated from an expensive elite private school. While we may sympathize with the pains of financing a basic education, fewer would shed a tear for someone who incurred massive debts hoping to purchase a spot among the U.S. elites. First, it is important to remember that this group is an exception, rather than the rule. Those attending Ivy League schools comprise a fraction of a percent of the country's college students. The vast majority of students (an estimated 73 percent in 2011) attend public schools, and only 9 percent attended flagship research schools.[41] The minority that do attend private schools may be wasting their money. Some data suggests that a student's choice in majors is a much stronger determinant of their incomes than the selectivity of their school.[42] While students may receive a very small bump in the average annual return on investment in education by

attending competitive schools, the decisive differences are between those with engineering, math, or computer science degrees and those who major in the arts or humanities. Still, questions about super-expensive schools seem to be a side show. The bulk of the middle class is being affected by the rising cost of local public schools.

Housing

Many analysts maintain that rising housing costs are the result of people buying larger homes, perhaps noting that the square footage of a new home has risen considerably over past decades.[43] The implication is that housing prices are driven up by quantitative increases in housing acquired, which could be considered an increase in living standards and perhaps a by-product of America's consumerism. Such a viewpoint misses the point that *new* housing may be getting bigger, but the U.S. housing construction market generally serves wealthier families, while relying on a trickle-down of older homes to supply the middle class and lower class with housing.[44] As Ohio State sociologist Rachel Dwyer explains, the rising size of *new* homes is an artifact of the construction industry's orientation toward serving the more affluent.[45]

Most American households are not moving into these big, new homes. Elizabeth Warren notes that the proportion of people living in older homes jumped by nearly 50 percent, with roughly 60 percent of the country living in a home older than 25 years, and 25 percent living in one older than 50 years.[46] The median owner-occupied home grew from 5.7 to 6.1 rooms, which is hardly a dramatic expansion of living space. Even if Americans purchased more living space, they paid a greater premium for it; although square footage rose on new home constructions by roughly 40 percent between 1985 and 2007, home values rose approximately 250 percent. Square footage costs and, in turn, overall shelter costs, have grown as a percentage of household income, despite the rising incidence of dual-earning families.

Those who see rising housing prices as a result of bigger or better housing structures are missing the key driver of home values: location and the central role that location plays in the disbursement of essential services. The cost of housing is primarily driven up by the cost of shelter (the physical property) and property taxes. Other housing-related costs have been stable, if they haven't been falling. These costs are about location. People have been spending more to get a foothold in particular communities. Cheap housing is available in the United States, but households have not collectively addressed their money problems by moving into low-cost areas.

People have strong incentives to live in "better" or more privileged communities, and communities have incentives to exclude those who are poorer than the typical resident. Spatial inequality and socioeconomic segregation interact with the U.S.'s decentralized system of financing and disbursing public services to create massive incentives for people to spend to the limits of their finances when choosing where to live, particularly if they have children. This is not simply a matter of the very rich excluding the riffraff. The rich exclude the upper-middle class, who exclude the middle-middle class, who exclude the lower-middle class, and so on. This is not just a matter of accessing better services and insulating one's family from social problems, but it is also a defensive measure that protects what is generally a family's most valuable asset. Housing prices have a record of being more secure in more expensive communities. While it is possible to find inexpensive housing in the United States, that housing can be in distressed communities, in places with little access to work, and in areas that can have infrastructure and essential services reminiscent of developing countries.

Housing, Community, and Essentials

What are people buying when they buy a home? They are not just buying the physical structure and the amenities of its property—a view from the front porch, number of cars that can fit in the garage, number of bathrooms, and so on—but also a foothold into a community, and with it the benefits and burdens of being part of that community. In the United States, public goods and services are often financed and administered at a local level, and being in a better-heeled community means sharing a better-financed system of public and communal resources with people who are less dependent on public and communal resources. Spatial inequality is very high, so the rich, moderately rich, middling, slightly poor, and very poor are all relatively unlikely to live together, as opposed to mixing more. The country allows serious social problems to fester in its more impoverished communities, while the public goods of wealthy communities can be genuinely outstanding by just about any society's standards. When people pay up for housing, they are purchasing access to public services and infrastructure. Housing in a pricier neighborhood *promises* better essentials.

There is some degree of uncertainty as to whether better-funded localities actually deliver higher-quality public schools and policing, or whether those who live in pricier places are more inclined to achieve educationally or avoid crime. In either case, the degree of spatial inequality among U.S. localities creates communities of haves and have-nots. Those who see

housing spending as a matter of people wanting McMansions may be overlooking these motives when making home purchasing decisions.

K–12 Schools

While K–12 schooling is fully socialized insofar as people do not directly pay for primary or secondary school tuition, households do indirectly purchase access to it through their choices about where to live. School quality can vary considerably between districts. For example, a recent analysis of math and reading scores suggest that sixth-grade students in places such as Los Altos (California), Mendham (New Jersey), or Westford (Massachusetts) were more than three grades ahead of an average district (e.g., New York City) and more than five grades ahead of poor districts such as Detroit, Cleveland, or Camden (New Jersey).[47] Econometric analysis finds that home values are significantly related to school performance.[48] School quality varies widely across neighborhoods, and wealthier neighborhoods tend to have better schools.

To the extent that people are purchasing access to a quality school district, they are purchasing education, and education has a well-documented relationship with earnings and well-being. Is the relationship causal? Is it that poor school districts fail their children or that poorer school districts are more populated by children who are disposed to do poorly in school? Some analyses suggest that school district plays a very minor role in a student's success. One recent study concluded that school districts accounted for 1.1 percent of variation in achievement, school-level factors for 1.7 percent, and teacher-level factors about 6.7 percent,[49] implying that more than 90 percent of a student's performance seems attributable to nonschool factors. About 32 percent is attributed to demographic factors, such as age, race/ethnicity, cognitive disability, poverty, nativity, and English fluency. The remaining 59 percent is attributed to student-level factors—some of them personal (e.g., a student's intelligence, drive, work habits, perseverance, attitude toward school) and others social (e.g., the influence of family, peers, or neighbors).

These kinds of findings suggest that people are overpaying on housing because they are situated in "good districts." The idea that district and school could *collectively* shape about 4 percent of a student's performance portrays the neighborhood school as a potential minor factor in shaping a child's success. It seems far more important that children get good teachers, a good home influence, positive peer influences, good genetics, and a productive disposition. But the influence of social factors also provides a case for overspending. Even if we accept the proposition that schools themselves

aren't decisive in shaping young people's academic achievement, parents might opt to raise their children in a community in which academic achievement and college ambitions are the norm. Put differently, people might overspend on housing to raise their children among other college-bound or higher socioeconomic status children. Many studies find that peers exert a substantial influence over children's academic achievement.[50] Raising one's child in a community where achievement is prevalent may give a child a better chance of being in a higher-achievement peer group. Conversely, raising children in a community in which distress is prevalent may make it more likely that one's own child grows up in peer groups that are adversely affected by distress.

Perceptions of school quality also affect a household's finances through its impact on home values. Perhaps the most compelling reason to value perceived "good" school districts is that other people believe them to be important, and these beliefs will affect the salability and market value of a person's home, which is typically the largest asset on a household's balance sheet. Even if the school district is wholly irrelevant to children's educational development and future employability, the home buyers' belief in its importance may help a family home retain or appreciate in value.

Access to Transportation and Work Opportunities

A second issue is access to work. This access can manifest itself in multiple ways. Affordable housing seems to prevail in places with high unemployment or little population—areas that are remote or wrestle with serious economic problems. While a family could save on shelter by moving to downtown Detroit or rural Mississippi, where employment opportunities (particularly well-paid ones) may be more scarce, and the move could result in a net loss after the forgone income of a weak job market is factored into the equation. Home values are also shaped by the length of commute and access to the transportation infrastructure.[51] Those who live in larger metro areas may have an opportunity to live in more affordable communities near job centers, but they will have to pay more for shorter commutes and access to public transit. It may be possible to find affordable housing in a large metro area, but it may involve hours of commuting. Someone has to watch the kids or take care of household business during the extended drive to and from work.

So while it is true that there are American communities in which houses can be bought for prices that might strike foreigners as absurdly low, many families cannot afford to live in them because it is hard to earn a living in the locales in which they are set. There may not be jobs that are available

nearby, and the jobs that can be found involve very long commutes. Commuting also involves costs, both in terms of transportation outlays and in terms of time. A single parent with two hours of daily commuting time must find someone to care for his or her children during the trip.

Public Safety and Emergency Services

Safety is another common motivator of housing choices. Many studies find a relationship between crime rates or factors that could affect the perceived risk of crime (e.g., a sex offender moving nearby, a local homicide).[52] While there is an abundant supply of homes that cost less than $100,000 in cities such as Detroit, New Orleans, St. Louis, Baltimore, or Newark, these locations have city-wide murder rates that are four or five times the national average, and violent crime rates reach nearly 1 percent of the population per year.[53] Media stories maintain that cities such as Detroit and New Orleans can have police response times that run several hours.[54]

On one hand, a closer consideration of the data suggests that fears about the true risk of crime and slow police response in low-cost neighborhoods may be exaggerated. The literature on the determinants of police response is scant, but one study of Houston-area response times suggests that police response tends to be faster in disadvantaged areas.[55] At the very least, there is a possibility that police response is not necessarily bad in poor neighborhoods. In terms of people's risk of crime, many observers believe that we tend to exaggerate our risk of being victimized, particularly by a stranger. Even in high-crime localities, the likelihood of being murdered is often a fraction of a percent, and two-thirds of murders are committed by victims' personal relations.[56]

Still, perception of crime risk affects home prices and, in turn, household wealth accumulation, much like perceptions of local school quality. Even if people see crime risk as minimal in just about any locality, they may still opt to live in a low crime area to ensure that their home maintains and accrues value.

Insulation from Housing Market Shocks

One of the biggest shocks of the 2008 crisis (both in emotional and financial terms) was the damage done to home values. People invest heavily in their homes and expect those investment to retain their values. The collapse in home values left many households "underwater"—with mortgage debts that were bigger than the value of the home itself. The crisis brought an epidemic of foreclosures. Observers found that these foreclosures were

more prevalent in lower-income communities,[57] and local foreclosures can have negative effects on home values.[58] In the years that followed the crash, housing in low-value neighborhoods widely failed to recover, even while those in higher-value places have done so.[59] These findings suggest that down-market homes are more exposed to losses in value during economic downturns and may be less likely to appreciate in tough economic environments. It might be a financially defensive play to invest in a home that is in as affluent a community as possible.

Potential to Purchase Access and Insulation

Money spent on housing can conceivably purchase access to many services and amenities that help improve living standards, and can help purchase insulation from society's problems. A better-financed community has the capacity to offer better libraries, recreational facilities, and other community services. Housing money can also be used to insulate a household from societal problems. For example, housing can be purchased that is far from the hundreds of hazardous waste sites in the United States, unlike the 4 percent of Americans who live within one mile of an EPA-designated superfund site, and the 13 percent who live within three miles.[60] To the extent that people benefit from being surrounded by others in better financial circumstances, who have higher education, or have more intact families, then people may benefit from living and raising their children in these types of social environments as well. The list of potential benefits could go on. The main point is that money people spend cannot easily be reduced to the frivolous consumption of oversized McMansions. In the United States, a place where socioeconomic segregation is high and intercommunity redistribution is low, gaining a foothold in a wealthier community means accessing better-financed goods and services that are essential to well-being, and perhaps safeguarding families' tremendous investment in their homes.

At the same time, Americans' collective struggle to "move on up" to a "better" neighborhood may involve some status consciousness or snobbery. While few of us would argue that people are getting their money's worth when they spend their way out of genuinely distressed communities, it is not entirely clear whether the value added in moving from a middling to high-end community offers much contribution to a person's health or economic prospects, net of their genes, job, family situation, personal habits and choices, luck, or other circumstances not related to membership in a community. The main rationale becomes financial, related to the presumption that buying up in a housing market is a more secure investment.

Still, there is little doubt that Americans collectively reject what would seem like the financially sensible strategy of purchasing a home that is below their means. It is hard to say whether this reluctance has objective merit or exists more purely as a result of our collective prejudices favoring those who are richer.

Market Failures to Deliver Value

Proponents of laissez-faire often believe that the free market is the socially optimal way of organizing a society's economic activities. Presumably, such an organizational scheme would make it easy for people to obtain things that they really need. In a free market, we might suppose that this comes from innovation, efficiency enhancements, and a willingness to cut profit margins in the face of both competitive and consumer pressures.

This scheme has worked very well in many sectors: apparel, consumer electronics, entertainment, home furnishings, appliances, cars, reading materials, and many other product markets. It has not succeeded as well in healthcare, child care, higher education, and housing. It isn't for lack of trying—the major mechanisms for lowering costs, such as foreign outsourcing, automation, or deskilling jobs, have certainly been attempted in healthcare and higher education but they just haven't succeeded (yet). Child care relies heavily on undocumented work arrangements, but the burden of even a low-paid worker is a lot to bear for the typical family. Private developers aren't collectively rushing to build residential developments to serve the bulk of society that lives at the middle or bottom of the economic pyramid. The free market simply has not succeeded in creating a bounty in these sectors.

What is interesting is that the United States has been particularly committed to the privatization of these markets, compared to other highly developed societies. A look abroad can be instructive, so we turn to international comparisons next.

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Chapter 7

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