Collectivized care

Markets have worked marvelously for providing necessities like food and shelter. Why not for health care?

BY RICHARD ESENBERG

Obamacare has become — sort of — operational. It has been a long wait.

The Affordable Care Act was given the softest open in history. It was a piece of public policy so wonderful in its beneficence and sage in its design that it could not be implemented until after the president was safely re-elected. Indeed, certain key provisions — such as the employer mandate and verification that persons receiving subsidies actually are entitled to them — are still not in place. In defiance of clear statutory language, they have been suspended until after the president's final mid-term elections.

Exemptions have been handed out like government cell phones. Numerous "glitches" — such as the fact that the law does not provide for the payment of premium subsidies in states like Wisconsin that have not set up an exchange — have been waved away. The president apparently will not be chained to the "false choice" of following the law or getting what he wants.

My guess is that the reluctance to fully implement Obamacare has not been rooted in a desire to avoid the political benefits that its wonders would confer on the Democrats. It seems more likely that the engineers wanted off the train before it wrecked.

But will it wreck? The short answer is that no one knows.

There is a sense in which Obamacare is neither fish nor fowl. It seeks to create incentives and penalties to induce, rather than coerce, businesses and individuals to do things that they absolutely must do if the scheme is to have a prayer of working.

But in the grand tradition of democratic decision-making, its carrots are small and its sticks, while large enough to hurt, may not be big enough to secure compliance. It is possible that a critical mass of employers and individuals will not offer or purchase coverage, and the entire contraption will fall apart.

Even if we avert a catastrophe, Obamacare will give us more of what is already problematic in how we purchase

health care in the United States. It will continue to move us away from health insurance and in the direction of collectivizing routine costs of care. "Insurance," as that term is used in every other context, is a hedge against sporadic and unpredictable costs that are too large to absorb. Car insurance, for example, doesn't cover routine maintenance. We insure our homes from catastrophic damage, but we don't buy grocery coverage.

But when it comes to health care, "insurance" has come to mean a contract through which we pay money to have someone else pay our bills. Obamacare doubles down on that, mandating coverage for routine costs that one would not think are necessary for most people to "insure" against. Recall how the republic was torn asunder over the GOP's suggestion that those employed by dissenting religious organizations might have to pay ten bucks out of pocket each month for birth control.

The common justification for collectivizing even routine and manageable health care costs is to say that "no one" should have to choose between health care and any other use for their resources. Markets in health care "can't work," we are told, because the demand is, as economists say, "inelastic." If you are sick or injured, you must go to the doctor or hospital. Things that are "essential," the argument continues, should not be rationed by price.

I am skeptical. We also must eat and be clothed and sheltered, yet markets have worked quite well in dramatically reducing the cost of — and improving — these necessities. We have, to be sure, stepped in to assist those who could not afford these things for themselves, but we haven't collectivized the way in which most of us are fed, clothed and housed.

Even if we avert a catastrophe, Obamacare will give us more of what is already problematic with health care in the United States.

As a result, markets, governed by the choices of consumers and producers, have reduced costs and generated innovation. Not everyone chooses wisely, and markets occasionally move in directions that must later be corrected, but, in the fairly near term, we generally reach the most efficient allocation of resources possible.

That is not the way of Obamacare. Its linchpin is the narrowing of consumer choice. One must purchase at least the prescribed amount of health care, and one may only choose from among a banded set of approved coverages.

It restricts the choices of producers as well. In the absence of functioning markets, care must be rationed and costs controlled. Obamacare must rely on top down approaches to control costs, trusting that experts, rather than patients and providers, can "bend the cost curve."

Again, I'm skeptical. There isn't one of the various panacea associated with Obamacare — things like payment per patient and not by service — that has not been tried by the government or private insurers in the past. Why we would believe something that has not worked in the past would work in the future is beyond me.

None of this means the system must collapse. It is quite possible that we will muddle along in an Obamacare world, never knowing what it may have cost us. It may be a world passably comfortable, akin to the cozy mediocrity of England's National Health Service. But it is unlikely to be as good as possible, and, in the end, that may be the real pity of the Affordable Care Act. ■

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