Don’t Count Health Care Chickens Before They’ve Hatched

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I raise chickens. No, I don’t own a farm, but for the four hens that live in my backyard, it might as well be one. And as you would expect with chickens, my wife and I receive a steady stream of edible eggs that will never hatch. Not having a rooster will do that.

I was reminded of our unhatched eggs after reading a commentary last month by *Columbia Daily Tribune* editor Henry J. Waters III. While I agree with Mr. Waters from time to time, I can’t help but disagree with his assessment that “what’s next” after the American Health Care Act is “single-payer.” Although it remains a persistent threat to good public policy, single-payer is a counted chicken from an unhatched egg—and an egg that may, in fact, never produce a bird.

I say this for several reasons.

First, the laws of economics are as true in health care policy as anyplace else. Top-down cost controls in single-payer systems have significant tradeoffs that become obvious when looking at the Medicaid program alone. Rather than introduce market mechanisms to control costs, Medicaid programs across the country more often pay doctors less to provide the same services, or simply cut services directly. That means fewer doctors and worse access for patients. Many taxpayers recognize this and believe this sorry dynamic shouldn’t be applied to the public writ large. We need markets; single-payer systems don’t deliver them.

Second, it isn't obvious to me that the window for Obamacare reform has closed. President Donald Trump and Speaker Paul Ryan have publicly declared their intent to move on to other legislative priorities like tax reform, but in the weeks since the AHCA's withdrawal, it's not clear that the AHCA itself is dead, or that reform will not come through another legislative vehicle. Keep in mind that Obamacare passed over a year after negotiations on the bill began in 2009; there is plenty of reason to believe that despite the posturing of legislative leadership, another attempt at reform is forthcoming.

Third, and perhaps most importantly, measures continue to flow into the present health care policy landscape, even as federal efforts remain in limbo. State-based legislative changes that would: do away with hospitals' certificate of need monopolies; empower patient–doctor relationships through direct primary care arrangements; open new avenues to care through licensing reforms; and introduce market mechanisms into existing state programs remain active issues in the states, and issues that Missouri legislators have often been on the forefront of implementing. And that's just the short list of currently debated reforms.

Surely federal health care efforts are an important part of the reform puzzle, but it presumes too much to think that federal officials are the only ones calling the shots in health care policy. For many years now, states have had a primary role in these decisions, from demurring on Obamacare exchanges to rejecting the law's unsustainable Medicaid expansion.

This isn't to say that the single-payer health care system Mr. Waters envisions is a political impossibility; market reformers need to take such efforts seriously. But the odds of it becoming law anytime soon are sufficiently unknowable that Mr. Waters is better served by not counting that chicken, at least not yet.

The mistakes of heavy government intervention in our health care over the last few decades are now coming home to roost. Rather than continue those mistakes, we should be reducing the government presence in our health care decisions, not increasing it. Hatching an even bigger government intervention in American health care seems more likely to produce a rotten egg than a productive hen.

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