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Why I Oppose National Health Care

By Megan McArdle

I know, most of you have already figured out why I oppose national health care. In a nutshell, I hate the poor and want them to die so that all my rich friends can use their bodies as mulch for their diamond ranches. But y'all keep asking, so here goes the longer explanation.

Basically, for me, it all boils down to public choice theory. Once we've got a comprehensive national health care plan, what are the government's incentives? I think they're bad, for the same reason the TSA is bad. I'm afraid that instead of Security Theater, we'll get Health Care Theater, where the government goes to elaborate lengths to convince us that we're getting the best possible health care, without actually providing it.

That's not just verbal theatrics. Agencies like Britain's NICE are a case in point. As long as people don't know that there are cancer treatments they're not getting, they're happy. Once they find out, satisfaction plunges. But the reason that people in Britain know about things like herceptin for early stage breast cancer is a robust private market in the US that experiments with this sort of thing.

So in the absence of a robust private US market, my assumption is that the government will focus on the apparent at the expense of the hard-to-measure. Innovation benefits future constituents who aren't voting now. Producing it is very expensive. On the other hand, cutting costs pleases voters this instant. This is, fundamentally, what cries to "use the government's negotiating power" with drug companies is about. Advocates of such a policy spend a lot of time arguing about whether pharmaceutical companies do, or do not, spend too much on marketing. This is besides the point. The government is not going to price to some unknowable socially optimal amount of pharma market power. It is going to price to what the voters want, which is to spend as little as possible right now.

It's not that I think that private companies wouldn't like to cut innovation. But in the presence of

even rudimentary competition, they can't. Monopolies are not innovative, whether they are public or private.

Advocates of this policy have a number of rejoinders to this, notably that NIH funding is responsible for a lot of innovation. This is true, but theoretical innovation is not the same thing as product innovation. We tend to think of innovation as a matter of a mad scientist somewhere making a Brilliant Discovery!!! but in fact, innovation is more often a matter of small steps towards perfection. Wal-Mart's revolution in supply chain management has been one of the most powerful factors influencing American productivity in recent decades. Yes, it was enabled by the computer revolution--but computers, by themselves, did not give Wal-Mart the idea of treating trucks like mobile warehouses, much less the expertise to do it.

In the case of pharma, what an NIH or academic researcher does is very, very different from what a pharma researcher does. They are no more interchangeable than theoretical physicists and civil engineers. An academic identifies targets. A pharma researcher finds out whether those targets can be activated with a molecule. Then he finds out whether that molecule can be made to reach the target. Is it small enough to be orally dosed? (Unless the disease you're after is fairly fatal, inability to orally dose is pretty much a drug-killer). Can it be made reliably? Can it be made cost-effectively? Can you scale production? It's not a viable drug if it takes one guy three weeks with a bunsen burner to knock out 3 doses.

Once you've produced a drug, found out that it's active on your targets, and produced more than a few milligrams of the stuff, you have to put it into animals, then people. Does your drug do anything in animal studies? Does it do too much, like, say, killing the patient? How about humans? Oral dosing is just the start. Does your drug actually get somewhere after it's swallowed, or do the stomach/liver chew it up? Is there any way to wrap it in a protective package long enough to let it reach its target? Do clinical trials show efficacy compared to placebo, or other drugs? How big is the market (in other words, how many people want it, how badly, and how much of an improvement is *your* drug)?

This is the stuff academic pharma doesn't do, and as you can see, without it, you don't have a drug; you have a theory. What the NIH does is supremely valuable. But so is all that "useless" effort at the pharmas.

Now, maybe government institutions could be made to produce innovations; I certainly think it's worth trying Dean Baker's suggestion that we should let the government try to set up an alternate scheme for drug discovery. Prizes also seem promising. But I want to see them work first, not after we've permanently broken the system. The one industry where the government is the sole buyer, defense, does not have an encouraging record of cost-effective, innovative procurement.

At this juncture in the conversation, someone almost always breaks in and says, "Why don't you tell

that to an uninsured person?" I have. Specifically, I told it to me. I was uninsured for more than two years after grad school, with an autoimmune disease and asthma. I was, if anything, even more militant than I am now about government takeover of insurance.

But you can also turn this around: why don't you tell some person who has a terminal condition that sorry, we can't afford to find a cure for their disease? There are no particularly happy choices here. The way I look at it, one hundred percent of the population is going to die of something that we can't currently cure, but might in the future . . . plus the population of the rest of the world, plus every future generation. If you worry about global warming, you should worry at least as hard about medical innovation.

The other major reason that I am against national health care is the increasing license it gives elites to wrap their claws around every aspect of everyone's life. Look at the uptick in stories on obesity in the context of health care reform. Fat people are a problem! They're killing themselves, and our budget! We must stop them! And what if people won't do it voluntarily? Because let's face it, so far, they won't. Making information, or fresh vegetables, available, hasn't worked--every intervention you can imagine on the voluntary front, and several involuntary ones, has already been tried either in supermarkets or public schools. Americans are getting fat because they're eating fattening foods, and not exercising. How far are we willing to go beyond calorie labelling on menus to get people to slim down?

These aren't just a way to save on health care; they're a way to extend and expand the cultural hegemony of wealthy white elites. No, seriously. Living a fit, active life is correlated with being healthier. But then, as an economist recently pointed out to me, so is being religious, being married, and living in a small town; how come we don't have any programs to promote these "healthy lifestyles"? When you listen to obesity experts, or health wonks, talk, their assertions boil down to the idea that overweight people are either too stupid to understand why they get fat, or have not yet been made sufficiently aware of society's disgust for their condition. Yet this does not describe any of the overweight people I have ever known, including the construction workers and office clerks at Ground Zero. All were very well aware that the burgers and fries they ate made them fat, and hitting the salad bar instead would probably help them lose weight. They either didn't care, or felt powerless to control their hunger. They were also very well aware that society thought they were disgusting, and many of them had internalized this message to the point of open despair. What does another public campaign about overeating have to offer them, other than oozing condescension?

Of course, the obese aren't the only troublesome bunch. The elderly are also wasting a lot of our hard earned money with their stupid "last six months" end-of-life care. Eliminating this waste is almost entirely the concern of men under 45 or 50, and women under 25. On the other hand, that describes a lot of the healthcare bureaucracy, especially in public health.

Once the government gets into the business of providing our health care, the government gets into

the business of deciding whose life matters, and how much. It gets into the business of deciding what we "really" want, where what we really want can never be a second chocolate eclair that might make us a size fourteen and raise the cost of treating us.

I realize that to most people, these are airy-fairy considerations that should be overridden by the many "practical" considerations of the awesomenes of central health care. Well, I'm actually pretty underwhelmed by that awesomeness, for reasons I'll happily elaborate elsewhere. But not here, because fundamentally, to me, the effect on the tax code and the relative efficiency of various sorts of bureaucracy are mostly beside the point. The real issue is the effect on future lives, and future freedom. And in my opinion, they way in overwhelmingly on the side of stopping further government encroachments into health care provision.

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