Comparing the demand for health care and aggregate food demand

The debate in the US over universal access to healthcare and the proper role of government has been going on, sometimes quietly and other times loudly, for more than a century. The earliest proposal to be put into legislative form was written in 1915 by a committee of the American Association of Labor Legislation providing "limited coverage to the working class and all others that earned less than $1200 a year" (http://tinyurl.com/crbrgjy).

In 1965, President Lyndon Johnson signed Medicare into law, providing universal health care for those 65 and older. The first Medicare card was issued to former President Harry Truman who, in 1949, had tried to get universal healthcare legislation enacted as a part of his Fair Deal. Medicaid coverage for low-income persons was also passed at that time.

During his first term in office, Bill Clinton proposed but failed to get healthcare legislation through Congress. His successor George W. Bush was able to add prescription coverage to the Medicare program. During the first two years of the presidency of Barak Obama the Affordable Care Act was passed. It has been the subject of debate ever since.

Our intent in this column is to step back from the current debate over the Affordable Care Act and look at the economic issues involved in healthcare markets when compared to aggregate food markets. Both are necessary for life, though the time frame in which the necessity becomes apparent is different.

For food, the lack of access to an adequate supply of food has immediate consequences, while many people can put off seeing a healthcare professional for an extended period of time and still live quite well. But incur a traumatic illness or injury and moments can make the difference between life and death; there is no time for negotiation between the buyer and the seller to come to agreement on a price.

While the timeframe in which the impact of not being able to purchase adequate food or medical insurance/healthcare may differ, both markets are coercive. And in each case the lack of access results in premature death. The same cannot be said for non-coercive markets like yachts and gold. Being excluded from those markets has little impact on one's lifespan.

A significant portion of the non-Medicare US population have access to health insurance through an employer-paid plan. These health plans work because non-conditional enrollment is limited to a few months after employment with an employer begins. As a result, they have a mix of young and old, those with few medical needs and those with greater medical needs. The larger the number participants, the less likely it is that a catastrophic medical event for any one individual will have a significant impact on the cost of the plan, and thus the participant's share of the premium cost.

In addition, employer-paid plans generally have a smaller proportion of people with catastrophic illnesses than the general population. This is true because many people with catastrophic illnesses find it difficult to maintain steady employment and thus drop out of these plans or are not included in the first place.

As independent operators, farmers do not have access to these employer-paid plans and must bear the full cost of a health insurance policy. That means they often purchase high deductible plans that cover catastrophic illnesses.

When farmers do have access to employer-paid plans it is generally because their spouse works for an employer with an insurance program. Over the years, we have seen a number of

spouses working off-farm, not because of the salary they earn, but to obtain health insurance for the farm family. And, the off-farm-employed spouses often continues to work until both are eligible for Medicare. Universal health insurance coverage would make it possible for a number of spouses to participate more fully in the farming operation.

As we listen to the health insurance debate we wish that more attention would be paid to the fact that the healthcare market, like agriculture, does not meet the textbook conditions of a free market; it is a coercive market in which the buyer can suffer significant consequences if they do not participate. The coerciveness in the health insurance market is not the result of any governmental action, but of the nature of the market itself.

By including the whole population in a government managed program that provides everyone access to healthcare, the overall degree of coercion is reduced. We have seen it work by providing seniors with Medicare.

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