

# Is there a Human Right to Medical Insurance?<sup>1</sup>

## I. Introduction

Paul Krugman (2004, 2005) has written a series of articles on our present socialized medical system.<sup>2</sup> Implicit in his publications is the claim that medical service is a human right, and that our present system does a poor job of providing for and safeguarding it, in that, in particular, not all people are covered by health insurance. Hence, we are an unjust society. Some of his criticisms are very telling.

The present paper argues, however, that his problems with the present system stem from its socialist and fascist elements, not from free enterprise, as he contends. Instead of calling for markets, freely determined prices and laissez faire capitalism for health care, Krugman urges that we go even further in the direction of medical central planning and government regulation, precisely the causes of the problems he mentions.

This is akin to complaining about the transmission of a car, when the reason it will not function is that all four of its tires are flat. To wit, Krugman blames the plight of our medical industry on – wait for it – too much competition, when the real problem is that we do not have nearly enough of this rare and precious element of free market economics.<sup>3</sup> It is precisely the *lack* of competition that is responsible for our medical difficulties.

We utilize section II of this paper in an attempt to shed light on the issue of human rights, and to ask if medical care can qualify in this regard. We reject all such claims. In section III we discuss problems on the supply side of medicine: entry restrictions for doctors. Section IV is given over to an analysis of the demand side of this market: the moral hazard imposed by the subsidy system on patients. The purpose of section V is to focus on yet two other aspects of the disarray of medical economics: the malpractice scandal, and the fact that medical socialism, just like socialism for the entire economy, leads to planning irrationality. In section VI we focus more narrowly on Krugman's specific criticisms. We conclude in section VII.

## II. Human rights

Many claim that health care is a human right and that only an unjust society such as our own would fail to provide adequate coverage in this regard.

The problem with this claim is that it is but a variant of positive rights, and thus implies obligations on the part of others to provide it. This is highly problematic. Which others should be so obliged? People in one's own city? State? Country? But why stop here? If it is truly a *human* right, then our obligations are to provide the objects of these rights for *everyone on earth*, a reductio ad absurdum that no one even contemplates, not even its supposed advocates.

Then, why stop at medical care? If it is truly a human right, what of food, clothing and shelter, etc., which, in many contexts, are even more important to the sustenance of life than medical care? For example, we can survive only a matter of days without food, and only hours or minutes without clothing and shelter (in very cold climates). But a healthy young person can live for decades without the attention of a physician. Why should not all of these things be human rights, in which case we are back in the sort of system that the late and unlamented U.S.S.R. bequeathed to the world.

Then, too, human rights are presumably timeless (Block, 1986). The negative right not to be murdered, not to be raped, not to be victimized by theft, etc., do hold true in all epochs. It is just as much a human rights violation to engage in any of these despicable acts 10,000, 1,000, 100, 10 years ago, or today. In contrast, it would have been literally *impossible* to provide today's level of medical care 10,000, 1,000, 100, 10 years previously, or even, by definition, a single year ago. Something which is *impossible* to respect or live up to can hardly be called a right. It is for these reasons that we must reject the claim that health care is a human right.

But is health care not a human right? Surely it is important that this service be made available to as many people as possible, even, to all citizens. Why do our present medical offerings fall so short of this reasonable goal? It is the contention of the present paper that our present health doldrums emanate not from the free enterprise system, but from the very opposite direction: too little economic freedom is allowed into this area of the economy.

### III. The supply side

What are the specifics? First of all, there are vast restrictions on entry into the industry. With government support, the American Medical Association (AMA) controls the number of new doctors allowed to practice with an iron fist. No new medical schools can be licensed without its approval. Moreover, it takes a dim view of extant institutions increasing the sizes of their freshman classes. It places barriers against the competition that would otherwise be applied to its members by foreign practitioners (Friedman, ch. 9).<sup>4</sup> For example, it requires that licensing examinations be conducted in the English language. Ostensibly, this is to improve the quality of health service, as it would be highly inefficient if a patient complained of a stomach-ache and the foreign non English speaking doctor started examining the head, or the foot.

But it is easy to pierce through this obfuscation. First of all there is pantomime. Only a physician with a room temperature IQ would look to either extremity of the patient when he pointed to his stomach and grimaced in pain.<sup>5</sup> Secondly, there are all sorts of tests (urine, blood, pulse, blood pressure) that indicate malaise; the sick person himself, through verbal transmission, is only one source of such information. Third, there are unconscious patients, where information through language cannot be forthcoming in any case. Fourth, there are clients who speak the same language as the foreign doctor. A physician from Russia, for example, could be expected to deal adequately with his fellow nationalists from that country. Fifth, there is such a thing as translators, who could

provide communication not only between the doctor and patient, but also to all other complementary labor services, such as nurses, technicians, other doctors, etc.

Yes, such additional services are not costless, but surely patients and would be foreign physicians should not have this option taken away from them by the AMA, certainly not in the name of promoting patient care. In any case, the additional medical expenses would likely fall far more by the addition of tens of thousands of new doctors than they would rise due to the hiring of additional translators. This is because, at the very least, the salaries of the former are vastly higher than those of the latter.

The present doctor shortage<sup>6</sup> is truly horrendous,<sup>7</sup> raising physicians' salaries into the stratosphere. This, perhaps, more than any other one phenomenon, is the cause of our present medical malaise.

Krugman complains about too much competition. But the problem lies in precisely the opposite direction: too little competition, fueled by monopolistic powers of the medical guild. It is no accident in this regard to find the health industry one of the serious laggards in the move toward computerization. There is simply less impetus in this direction than in more competitive areas of the economy. The respected *Economist* magazine (4/30/05, pp. 65-67) titles its coverage of this phenomenon "The no-computer virus: the inability, and reluctance, of doctors and hospitals to use information technology more widely is killing thousands of people." The difficulty is that patients' records are not readily available to physicians. In their absence, they cannot as easily tailor care to the specific needs of the patient, and are thus less likely to prescribe the correct treatment. *If* there were competition in this industry, then those doctors and hospitals who availed themselves of the new (well, decades old) computer technology could steal a march on their counterparts who did not. In the absence of competition, this process is stultified.<sup>8</sup>

#### IV. The demand side

If medical fascism is responsible for the disarray in the health field on the supply side, then medical socialism plays a similar role on the demand side. Medicaid<sup>9</sup> and other such government programs without deductibles or co payments give rise to the problem of "moral hazard." If something is given away for free or nearly so, people tend to use it as if those were its real costs.

The same considerations apply to "free" medical care. It, too, tends to be vastly overused, compared to the situation where the full economic costs of it must be paid. In other words, demand curves slope in a downward direction, and at zero or near zero prices, they typically extend to indefinitely large quantities. As well, doctors have incentives to do extra tests to build up fees, as well as to ward off malpractice lawsuits. Medicaid "mills" have arisen as a result.<sup>10</sup>

But is it not a good thing that people can splurge under these conditions, whether for chicken dinners or the care of health professionals? Not a bit of it. It cannot be denied that for those few lucky enough to indulge their tastes in this regard, the system is

beneficial. But, there are only so many chickens or physicians' hours available at any given time. If group A has more of these items, then, perforce, group B must have fewer. And if group A is using them not for important purposes for rather frivolous ones, that makes the waste even the more intolerable.

We must tread carefully here, lest we involve ourselves in illicit interpersonal comparisons of utility (Rothbard, 1997). After all, even under full free enterprise, the rich, presumably, would enjoy more doctor's care and chicken dinners than the poor. However, can we make the point that these goods and services would be better utilized by B than A? It all depends on the starting point.<sup>11</sup> In the free enterprise system, our default position is that chickens and doctors were allocated to people in accordance with their purchasing activity. We assume that whatever ensued from this process was the rational or just allocation of these items between them, because it was based on voluntary choices of all concerned. Then, an alien presence, government, came along and orchestrated matters so that A could now step up its use of these benefits, forcing B to do with less. Since this transfer came about through compulsion, we can no longer say the resulting allocation maximizes welfare.<sup>12</sup> The burden of proof, in other words, rests with those who claim that this new allocation, A wasting, B wanting, is preferable to the old one, and this they have not so much attempted to do, let alone succeeded in this Quixotic venture.

But what about private insurance? Surely, there can be no principled objection to such an institution. If a firm in this industry fails to make adequate provision for co-payments and deductibles, it will go bankrupt, and its place taken by other more rational companies. Or, to anticipate Krugman's criticisms, if their administrative costs are too high, a similar fate will await them.

Imagine a system where the number of physicians rose greatly, and salaries commanded by doctors fell commensurably. No more long queues of patients awaiting medical attention. At least no more than the waits now undergone by customers at barbers, cleaning stores, haberdashers, etc. No longer would a 6-10 hour wait in the emergency room be a usual occurrence.<sup>13</sup> Instead, doctors are as available to the public as now are skilled auto mechanics or air conditioner technicians, and earning compensation only slightly higher than theirs.<sup>14</sup> In one fell swoop the need for medical insurance would all but disappear. No one purchases analogous insurance coverage for these other services, nor would they, likely, do so for health care under these assumptions. Food and shelter are, arguably, more important than medical attention.<sup>15</sup> Without the latter, only the sick will die. But in the absence of something to eat, none of us can survive for more than a week or so, and the lives of most of us would become very precarious in far shorter time than that.

If there were a vast conspiracy<sup>16</sup> to limit supplies in these other areas, there would probably be a similar desperation regarding them as there is now for medical coverage. There would be a great demand for food, clothing and shelter insurance; not everyone would be able to obtain it. There would be panic in behalf of those who have too little coverage for these items or none at all. But the fault would not be with "too many competitors," as Krugman would have it. Rather, it would stem from the fact that with

limitations on entry into these fields, prices would skyrocket. If housing and food and, yes, medical care are all reasonably priced, either insurance for these items will be cheap or non-existent, because no one would want them. Extrapolating from present practices with food and shelter (no one now purchases insurance for them)<sup>17</sup> it is most likely that with vastly lower medical expenditures, due to taking down the barriers for entry into this field that is part and parcel of free enterprise, insurance for them will become a thing of the past, and with it our present concerns for those without such coverage. For no one will need any such protection.

All economic goods must be rationed in some fashion. The only choice we have is what type of rationing mechanism will be used--an efficient (low-cost) one, or an inefficient one. There is no way any economic good can be provided without some kind of rationing mechanism. Medical care will be rationed--and by some less preferable system to the market--if it is made "free."<sup>18</sup> In the case of Canada, the rationing comes courtesy of waiting lists for services, very long ones. So much so that in a case brought by Dr. Jacques Chaoulli,<sup>19</sup> the Canadian Supreme Court, no bastion of free enterprise, was so disgusted with the long queues that they went against decades of practice and opened the door for -- wait for it, horrors!, "capitalist acts between consenting adults" (Nozick, 1974, 163) in the health industry, private medical care.<sup>20 21</sup>

How and why did private insurance for health care first arise?<sup>22</sup> It was due in part to wage and price legislation during World War II<sup>23</sup> and part to a unique aspect of our tax system. During this time, the wage controls that went along with the price controls, effectively became maximum wage rates. Employers trying to hire more workers offered them non-wage benefits that were not subject to the controls. Although private health insurance existed before that,<sup>24</sup> because such benefits were 'tax free' to the employees, i.e., not subject to income or Social Security taxation, they became a favorite form of non-wage compensation, and, for the same reason, remain so to this day.<sup>25</sup>

Maximum wages,<sup>26</sup> unlike the more familiar minimum wage legislation that sets up surpluses, actually creates shortages. At artificially reduced wages, employers demand more in the way of hours of work than is supplied by workers. Demand exceeds supply, and firms must compete, desperately, for workers. One way around this law, a black market as it were, would be to offer more fringe benefits, as a substitute for the higher wages that are precluded by this enactment. What form would this extra non-wage payment take? Theoretically, it could take just about any form: use of a "free" automobile, restaurant meals, groceries, clothes, toys, candy, whatever. In the event, however, the one fringe benefit seized upon by employers was medical insurance coverage. This was accidental, based on our tax system, in that the additional payment could otherwise have taken just about any form. However, coupled with restrictions on entry for medical practitioners, this tax-free institution led directly to our present difficulties with "lack of health care insurance coverage" for many other people.

As Friedman (2001) brilliantly explains:

"No third party is involved when we shop at a supermarket. We pay the supermarket clerk directly. The same for gasoline for our car, clothes for our back, and so on down the line. Why, by contrast,

are most medical payments made by third parties? The answer for the United States begins with the fact that medical-care expenditures are exempt from the income tax if, and only if, medical care is provided by the employer.”

And, according to the insightful analysis of “why U.S. health spending towers over that of other countries with much older populations” by Reinhardt, et al (2004), “Prominent among the reasons are ... a highly complex and fragmented payment system that weakens the demand side of the health sector and entails high administrative costs.”

This unwise government policy<sup>27</sup> of subsidies for selected groups of employees set in motion a whole set of expectations, an institution as it were, of private medical insurance. This industry has become deeply embedded in the bowels of our economy. To the extent it is truly inefficient, it will eventually be weeded out by the profit and loss system of free enterprise. There are indications that this is even now occurring. Estimates are that an average General Motors product costs some \$1,500 in health care costs (<http://www.newstarget.com/004785.html>), far more than many other very much more necessary factors of production that go into manufacturing this product. Quite possibly a large part of the financial malaise of this corporation is accounted for by overly generous agreements with unions along these lines in the past.

On the other hand, there is nothing intrinsically wrong with payments in kind, in lieu of additional salary. Only the market can ultimately determine if such an institution can long endure. As a matter of economic history, not praxeology, one can say however that there are several reasons to believe it will not last in the absence of other or continuing governmental subsidies to this end.<sup>28</sup> First of all, money is the most fungible of all possible payments. It is only in the case that the employee would have spent the addition to his salary in exactly the same way as the payment in kind that such a system has any chance of continuing. But this is truly rare. Which would you rather have: a bicycle, a tennis racket, a pair of shoes, skis, and a subscription to this journal, or the monetary costs of all of these, say, \$1000 exactly. It is only if you would have spent your money on precisely these items that there is even a chance you would prefer the former to the latter, and here only if the act of shopping for yourself is a negative. Similarly, most people would prefer to purchase their own medical insurance, if they wanted any in the first place. It is only if there are strong economies of scale in the making of such purchases that it would pay for the employer to do so in behalf of his employees. However, it is far from clear why this should be the case only for medical insurance, and not for the insurance of cars, food, toys, houses against fire, etc., let alone for outright purchases of these items.

It is time, it is long past time, that we disregarded the red herring of medical insurance, private or public, and looked to the underlying realities. Contrary to Krugman, this is *not* the source of our present medical difficulties as a society.

## V. Medical malpractice and planning irrationality

### 1. Medical malpractice

Medical malpractice insurance rates have gone through the roof, and there seems to be no end in sight in this regard.<sup>29</sup> This is problematic on two grounds. First, it raises the overall cost of health services. Second, it leads doctors away from practicing medicine with the well being of the patient as their only concern. Now, they must keep one eye out for defending against future malpractice lawsuits. To this end they will run up the bill with many very often expensive tests in order to protect themselves from lawyers in future. This attempt to serve two masters, attorneys and sick people, must necessarily detract from that which could otherwise be done for the latter.

This problem emanates from two sources. In their quest for a protected monopoly, mainstream doctors first had to ride roughshod over competing alternative modes of health care: chiropractors, acupuncturists - traditional Chinese medicine doctors, naturopaths, Reiki practitioners, followers of holistic medicine, homeopathic physicians; they had to disparage and demean these competitors (Friedman, 1962; Starr, 1982). In doing so they delegitimized other health practitioners on the grounds of not meeting quality standards. Obviously, this provided lawyers the opportunity to create an entire industry suing doctors on the basis of "the standard of care." What comes around goes around!<sup>30</sup>

The second cause of this phenomenon is Coase (1960). This is a highly influential article, indeed, a seminal one; it launched an entire sub-discipline of both law and economics,<sup>31</sup> and is the most widely quoted of all publications in the latter field (Shapiro, 1996, 751). Coase argued that proper law should be focused on maximizing G.D.P. In lawsuits, this could be done by ensuring that the least cost avoider of an accident, or a "bad" result, one reducing G.D.P., was held financially responsible for it.<sup>32</sup> And who would be the least cost avoider in any interaction between a physician and his patient? Why, the ones with greater knowledge of the subject. And this of course would be the doctors. So, hold them responsible for any maladies that arose as a result of the interaction between them.

This is not necessarily to say that any judge cited Coase (1960) in any medical malpractice suit. Rather, it is to focus on the fact that this article took both professions by storm, and is part and parcel of the intellectual armament of the practitioners of each. Certainly, the Coasean analysis strengthened the institution of medical malpractice as we now know it, even if, strictly speaking, it cannot be fully blamed for it.

Apart from its antecedents, it is clear that there has been a strong inflationary effect of malpractice insurance for doctors on overall medical care. It could scarcely be otherwise. When gigantic awards are made to medical plaintiffs, the costs of insurance must rise. And this, in turn, lifts the payments for all people for these services.

How can this problem best be addressed in the free society? Simple: allow contracts between doctors and sick people to prevail over court decisions regarding unconscionability. Here, there would be at least two and perhaps many more kinds of agreements between the two parties. At one extreme, caveat emptor would rule, entirely. The physicians would guarantee nothing, absolutely nothing, in terms of practice, well-

being of the patient, or anything else for that matter. Their efforts would come from internal sources, and also from reputational effects on other customers. That is, even here they would still be highly motivated to do a good job, lest patients desert them in droves. Such contracts would be relatively cheap. Here, patients would waive their right to sue (except possibly in the case of malice, and perhaps not even here) in order to obtain much needed expert advice and therapy. No longer would doctors order needless tests and feel beholden to societal losers with attitudes of entitlement out of fear of future litigation. Medical practice would cease to be a legal landmine, a court case waiting to happen.

Of course, at the other pole, patients would also have the right to contract with a willing doctor who would offer a guaranteed outcome of some sort. Needless to say, the payment for medical services under these assumptions, similar to what occurs at present, would be ever so much higher than under the other legal rule.

It is hardly necessary to say that courts would render invalid any kind of caveat emptor contract that did not allow aggrieved patients to sue for damages. Judges are hardly disinterested parties in such determinations, as such cheap medicine would greatly reduce demand for court services. And, yet, it is a basic premise of the libertarian philosophy that people should have the option of no fault contracts with doctors.

## 2. Planning irrationality

In the bad old U.S.S.R. there were three problems of socialism. First, incentives. Why should anyone work harder or smarter, if the rewards for so doing were only related very, very indirectly to such efforts? The only reason to do so was out of benevolence for one's fellow creatures, and/or philosophical adherence to the overall system. But for most people who are neither Mother Teresas nor ideological fanatics, these are weak reeds indeed on the basis of which to buttress an entire economic system. The second problem was information (Hayek, 1948; Boettke, 1991). How does local knowledge of specific situations get incorporated into the overall plan? When there is a freely functioning price system, this is no problem. If an entrepreneur knows of an undervalued factor of production, he merely purchases it, raising its price. Millions of acts of this sort tend to promote prices that truly reflect alternative costs. But when prices are either non-existent, or based on bureaucratic whim, not free markets, they cannot play any such role. Third, and most important, is that without private property rights, and busy entrepreneurs actively appraising resources, no rational prices can be generated, even if the two previous problems were somehow solved, which they cannot be.<sup>33</sup> Should we buy one tractor or hire 30 more farm workers? How about two tons of coal scans versus three tons of iron? Without markets based on private property rights, these questions are *impossible* to answer in any *rational* way.

What defenders of medical socialism in the U.S. fail to realize is that these three difficulties also challenge their pet nostrums. Consider just the third difficulty, creating rational prices: Should we buy one MRI or hire more 30 nurses? How about two pet scans versus 20 doctors? These questions are also *impossible* to answer without market prices. Of course, it is true that these problems will not be as bad in a socialist medical

industry in the U.S. as they were for the entire Soviet economy. We still do have a modicum of private property rights in this country.<sup>34</sup> The medical industry still must pay market prices for floor sweepers, towels, bandages, stethoscopes, etc.<sup>35</sup> But, the analogy with the U.S.S.R. still holds, since they, too, had access to the Sears and Roebuck catalogue, and could always send spies to western department stores and supermarkets to ferret out market prices.

## VI. Krugman's case for medical socialism

Let us now more directly confront the Krugman case for socialized medicine.<sup>36</sup> He (4/22/05) starts out complaining that private health care insurance companies spend about 15% of premium payments on administration, while the equivalent figure for their public counterparts, Medicare and Medicaid, is only some 4%.<sup>37</sup> But here we discern the central planning mentality (Mises, 1981, Hoppe, 1989) in operation. According to Krugman's stance, it would appear, the lower the administrative costs the better.<sup>38</sup> He (4/22/05) states: "because we rely much more heavily than anyone else on private insurance, our total administrative costs are much higher."<sup>39</sup> But at zero costs of administration, no one could keep track of anything, and the entire enterprise would fall apart. If absolute zero is not the optimal amount, then it is insufficient to claim that 4% is preferable to 15%. Krugman must either furnish us with the ideal percentage of total costs spent on administration, and/or with proof that 4% is closer to this optimal percentage than is 15%. This, of course, he has not done. Indeed, he cannot do any such thing, since it is only the market, not people with a bureaucratic (Mises, 1969) central planning mentality such as Krugman,<sup>40</sup> that can make any such determination.

Professor Krugman (4/22/05) seems mightily exercised by the fact that "Public insurance plans have far less bureaucracy because they don't try to screen out high-risk clients or charge them higher fees." But unless high risk clients are either charged more or screened out entirely, the institution being described is not at all *insurance* but, rather, *welfare*. Take fire *insurance* as a case in point. If an owner installs a sprinkler system, rates will likely decrease. Owners of wooden structures with exposed wiring will either be charged more than their counterparts with safe wiring and constructed of brick, or will be eschewed entirely.<sup>41</sup> One of the basic functions of such insurance is to promote safety, and this is done precisely with pricing measures of this sort.<sup>42</sup>

Similarly, with health. Why should insurance function any differently<sup>43</sup> in this context? Lower rates are given to younger people, those who do not smoke, are not obese, do not engage in risky sexual behavior,<sup>44</sup> etc. Here again we find the invisible hand at work. Insurance companies are led as if by Adam Smith's (1776) discovery; in an attempt to earn profits, they are led to promote good health on the part of their clients, even though this goal may well have been no part of their original intention. Nothing of this can be said in behalf of public medical "insurance."

What are we to make of this claim (Krugman, 4/22/05): "And the costs directly incurred by insurers are only half the story. Doctors 'must hire office personnel just to deal with the insurance companies,' Dr. Atul Gawande, a practicing physician, wrote in

The *New Yorker*: ‘A well-run office can get the insurer's rejection rate down from 30 percent to, say, 15 percent. That's how a doctor makes money. ... It's a war with insurance, every step of the way.’”

First off, there ought to be a recall of the Ph.D. degree<sup>45</sup> for any economist such as Krugman who acquiesces in the notion, let alone cites it in support of an argument, that commercial relations are akin to a “war.” In the market, *all* interaction is strictly voluntary; no one uses violence on anyone else, without permission. And not only that. It is necessarily *beneficial* in the *ex ante* sense of anticipations: no one would so much as buy (sell) a newspaper for \$.50 did he not value it more (less) than that amount. Did Dr. Gawande not gain more from his association with the insurer than it cost him in his own assessment, we can rest assured he would not be dealing with them. For a “practicing physician” to make such an elementary economic error as to equate mutually agreed upon contractual arrangements with “war” is perhaps understandable. He is economically illiterate. For Professor Krugman to fall for this fallacy boggles the imagination.

The real reason the insurer is rejecting applications is that the cost of provision is so high<sup>46</sup>, and the firm wants to keep costs down so as to not only be competitive, but even to stay in business. Competition, Krugman notwithstanding to the contrary, trims fat and makes for a leaner, meaner operation. Or does this economist who opposes competition, actually favor monopoly?

Then, too, there is a matter of bargaining. When someone shops for an auto and is told that the price is \$20,000, typically he will try several other dealers to see if he can get a better price. He will try to play one off against the other. This process tends to keep prices lower than what otherwise would have prevailed. But when a doctor tells him an operation will cost that same \$20,000, he does not even think along these lines. Instead, he abjectly acquiesces. Why should he worry about the price, or try to get it reduced? He pays nothing out of pocket for this operation, or at most a small fixed amount unrelated to the total cost. States Friedman (2001) in this regard:

“Two simple observations are key to explaining both the high level of spending on medical care and the dissatisfaction with that spending. The first is that most payments to physicians or hospitals or other caregivers for medical care are made not by the patient but by a third party — an insurance company or employer or governmental body. The second is that nobody spends somebody else’s money as wisely or as frugally as he spends his own.”

Who, then, plays the vital (quasi market) role of attempting to keep medical costs from rising? Why, the very self same insurance agency so heavily castigated by Krugman. According to him (Krugman 4/22/05), however, “private insurers generally don't compete by delivering care at lower cost. Instead, they ‘compete on the basis of risk selection’ -- that is, by turning away people who are likely to have high medical bills and by refusing or delaying any payment they can.”

Don’t try to deliver care at a lower cost? Then why all this niggardliness about which he complains so bitterly? And a word about “turning away” customers. An insurance company will insure *any* house against fire, even if the dwelling under

discussion is *at this very moment* burning! This assumes there are no government laws to the contrary, and that the premium is high enough. For example, I, fortunately, have a house worth \$1 million. Unfortunately, it is currently on fire. Will I be able to get insurance under these circumstances? Of course. For instance, if I pay a premium of \$1.5 million. That ought to (more than) defray the costs of the insurance firm for “protecting” me from the ravages of this conflagration as I sign the contract. Would I do any such thing? Of course not. This is a silly case. But it is not that the insurance company “turns me away.” Yes, they “turn me away” at any price I am willing to pay (less than \$1 million), but not at a price on the basis of which they can earn a profit.

In like manner, if I am at death’s door there is still *some* premium for which the insurance company will sign me up. It will have to be high enough, however, for them to earn an expected profit. But it would be the rare patient on his death-bed who would be willing to pay such a sum of money.

Krugman (4/22/05) is entirely correct in stating “Yet the cost of providing medical care to those denied private insurance doesn't go away. If individuals are poor, or if medical expenses impoverish them, they are covered by Medicaid.” But this is hardly the fault of the market, nor yet competition, his favorite whipping boys. Rather this is due to the fact that the government has seen fit to create a socialist – fascist medical system. Without it, these costs would indeed “go away,” or at least become radically reduced. Without government intervention in the health care market through subsidies on the one hand and government-created monopolies of physician and other health care supply on the other, supply and demand would tend to result in a market allocation of health care services where the amount demanded would equal the amount supplied.

How then could the poor and sickly survive under a pure free enterprise system? Simple. Medical costs would be significantly lower than at present since entry to the medical profession would not be artificially limited. Further, the waste attendant upon moral hazard would no longer be in play. Customers would have ordinary incentives to bargain with health care providers, as they do now in virtually every other arena of the economy. With costs so much lower than at present, private charity would be more than sufficient to cover the needs of the sick, the elderly and the poor.<sup>47</sup> These latter are today taken care of with regard to their needs for food, clothing and shelter,<sup>48</sup> given the relatively freer markets that prevail in these sectors of the economy. There is little reason to doubt medical care could be placed on a similar footing.

According to Krugman (4/22/05) “So we've created a vast and hugely expensive insurance bureaucracy that accomplishes nothing. The resources spent by private insurers don't reduce overall costs; they simply shift those costs to other people and institutions. It's perverse but true that this system, which insures only 85 percent of the population, costs much more than we would pay for a system that covered everyone.”

This is an empirical claim, so there can be no logical proof that it is always and ever fallacious. Yet this is by far the most likely situation. Suppose we move from say, 85% to 100% in terms of medical insurance. The new total costs include adding coverage

for, presumably, the sickest, but also the healthiest groups in the population – the former because they could not previously attain coverage, the latter due to the fact that they did not seek it out. If these two elements balance one another, and there are no economies or diseconomies of scale, then the presumption is that this move will add roughly 15% to health insurance expenditures, as per Krugman’s calculations. As against that, there will be a saving of all the present administrative efforts to deny coverage to any individual.

But this by no means exhausts all such effects. For not only must a decision be made as to whether or not to offer coverage to all those who apply for it, the premium levels must also be determined. This is surely a more complex issue than merely giving a “yes” or “no” answer to a patient. And, as we have seen, at least theoretically, it will *never* pay a firm to turn away *any* potential customer, provided only that the premium level that (more than) compensates the firm for the additional risk they must undertake.

Given these considerations, it is at least possible that there will be *no* reduction in administrative costs to offset the undoubted increases attendant upon raising insurance coverage from 85% to 100% of the population.<sup>49</sup> Nor can we see our way clear to agreeing with Krugman when he states:

“... in the U.S. system, medical costs act as a tax on employment. For example, General Motors is losing money on every car it makes because of the burden of health care costs. As a result, it may be forced to lay off thousands of workers, or may even go out of business. Yet the insurance premiums saved by firing workers are no saving at all to society as a whole: somebody still ends up paying the bills.”

First of all, he is seriously amiss when he likens tax to an in kind salary payment. The former is coercive; the latter is not.<sup>50</sup> As we have seen, the impetus for this sort of otherwise inefficient manner of paying compensation to workers stems from governmental maximum wage policies. But this in turn emanates from Krugman’s favorite institution: coercive government.<sup>51</sup> Secondly, if General Motors goes broke, for this or any other reason, so much the worse for it, its managers, its employees and its stockholders. Bankruptcy is a necessary and healthy aspect of the economy. It transfers resources from those incapable of conducting business satisfactorily to others with better ideas and/or more ability to carry through with them. If no old firms were ever allowed to be turfed out, there would be just that much less room for new entrepreneurs. And third, as we have also seen, it is simply false to claim that there will be “no saving at all” to anyone. It is almost an empirical certainty that there will be cost savings when the policy of payments in kind comes to an end, and with it the firms that have so long perpetrated it.

Krugman ends this column (5/22/05) with another crack at competition: “Why do we put up with such an expensive, counterproductive health care system? Vested interests play an important role. But we also suffer from ideological blinders: decades of indoctrination in the virtues of market competition and the evils of big government have left many Americans unable to comprehend the idea that sometimes competition is the problem, not the solution.”

To be sure it is not a necessary truth that competition always has good effects. There are indeed certain realms in which we do not welcome it. For example, consider an “industry” which includes “Murder, Inc.” as a firm. Here, competition would lead to cheaper and more efficient murders, something to be greatly regretted. But still, even here competition would lead to a more efficient and less expensive product. It is just that we do not at all relish this “service.”

What of competition among insurance companies to rein in out-of-control medical costs? A better way to do this would be to eliminate the moral hazard necessarily tied to subsidization, and restrictions on entry into medical practice. But *given* these impediments, without the competition so reviled by Krugman prices would be even *higher*. The tendency to utilize health care frivolously would be even more deeply embedded in the social and economic fabric. This will of course benefit some hypochondriacs, but it is difficult to see how this will be of help systemically.

Krugman (4/30/05) starts off bewailing the fact that “20 million working Americans are uninsured ... for basic health care.” But this is surely the exact wrong way to go about addressing the problem of out-of-control medical and health costs. More than 20 million Americans are uninsured for homelessness, starvation, nakedness, to say nothing of being without paper clips, ink toner and rubber band insurance. Yet, none of these other lacunae count as crises, since none of these items, food, clothing and shelter, as well as the office supplies, are in artificially short supply.<sup>52</sup> The same, unfortunately, cannot be said of physicians’ services. Far better to address this, the core of the problem, rather than worry about peripheral issues, such as the one pointed to by Krugman.

Professor Krugman (4/30/05) waxes eloquent about “our huge medical bureaucracy” comprised of “two million to three million Americans.” A goodly number of these, however, come to us courtesy of the government, Krugman’s favorite institution. Then, there are those hired by private firms, but many of them are put into place only to deal with bureaucratic requirements. In a free society, none of these people would have been employed in any such manner. All of them could have been doing honest productive work, producing goods and services actually valued by consumers. On the other hand, all industries without exception need clerks to keep records, reduce risk, promote the product, deal with consumer complaints, etc. To this end there are accountants, lawyers, insurers, advertisers, managers, marketers, and yes bureaucrats, but non-governmental ones.

Krugman (4/30/05) offers us a choice between support of the status quo, courtesy of the Health Insurance Association of America, and the Clintonian health plan for socialized medicine.<sup>53</sup> Of the two, the former is vastly preferable. Has Krugman learned nothing from the demise of the economic system of the U.S.S.R., or from the economic arteriosclerosis of North Korea and Cuba? Socialism does not work in any country, the U.S. very much included. Nor does it function in any industry, and health care is not at all an exception to this general rule.

However, there is a third alternative to the two put forth by Krugman. It is called the free enterprise system, and as Smith (1776) demonstrated several centuries ago, this is the last best hope for a well functioning economy. Laissez faire in health care<sup>54</sup> – no government involvement whatsoever<sup>55</sup> – is far preferable to either of Krugman’s alternatives.<sup>56</sup>

In Krugman’s view (4/30/05), “America is ruled by conservatives.” In their view, “U.S. healthcare is doing just fine” since it is a “market based system.” It is nothing of the sort. Free markets do not allow suppliers to restrict entry into an industry from would-be competitors; they do not give away services virtually for free, unleashing moral hazard problems on a grand scale.

Krugman (4/30/05) criticizes “Martin Feldstein(’s) ... health investment-based personal accounts.” Krugman and I both oppose this plan, albeit for opposite reasons. For Krugman, the Feldstein plan is too market-based; nothing, it would appear, but pure socialism, unadulterated, will do for him. For me, the Feldstein plan is too socialist; market socialism is still socialism.<sup>57</sup> Then, too, this proposal is compulsory. We have no such “plans” for food, clothing and shelter, and a good thing too. Why drag in from the disaster of social security, the discredited personal account type of interventionism? Government-dictated savings “plans” are simply not compatible with free markets, and neither are any health analogs.

Let us end this paper by considering one last insight on the part of Krugman (4/22/05):

“The United States spends far more on health care than other advanced countries. Yet we don't appear to receive more medical services. And we have lower life-expectancy and higher infant-mortality rates than countries that spend less than half as much per person.”

Anderson’s (2005) answer to this Krugman sally is definitive. He states:

“Krugman's reasoning is quite simple. If we were to go to socialist medicine, it would be cheaper than what exists right now *and* nothing else would change. All of us would receive the same care we do now—or perhaps even superior care...

“Indeed, the Krugman ‘solution’—socialization and price controls (no doubt, he also would later advocate that the government seize drug companies as well) would almost certainly propel us to receive the same "high quality" medical care given to the nation's prisoners.”<sup>58</sup>

## VII. Conclusion

So ingrained in the public consciousness is dependence upon medical protection being a province of government,<sup>59</sup> that most people, even careful analysts in other fields of economics, cannot imagine how laissez faire capitalism could function in this field.

But it can, it can. Many of the statist accretions to this field are less than a century old. At one time in history, health care was relatively freer. Of course, at that time modern technology was not available, so the common man can dismiss that epoch as the dark ages of medicine. But we have made great strides since that time not because of government interference, but despite it.

Another hoary fallacy is that hospital care is so expensive that only government can provide it. This claim is problematic for two reasons. One, it is the state that makes health service so costly in the first place, but restricting entry into the medical profession, by promoting moral hazard problems, by reducing, nay, all but eliminating our natural tendency to “barter and truck” (Smith, 1776), that is, bargain with providers over prices. Two, even if the services of health care professionals were intrinsically expensive (which it is not) still, the government is not the source of wealth. It does not have at its disposal one penny it did not first mulct from the private sector. Then, too, there is the horrendous problem of central medical planning. We seem to have learned nothing from the demise of the Soviet system of economics.

I conclude that the free enterprise system that has brought us so much at lower and lower real costs (think Walmart, computers), can do the same thing in the health industry. There is nothing unique about medical practice that renders it immune from the laws of economics. Therefore, let us privatize this industry, let us cut the government fetters that now stultify it, let us have a free enterprise health care system.

Last but not least, it is important to mention the moral dimension of this issue. Economic efficiency is not the only desiderata, in this case. When government organizes a sector of the economy, it must of necessity do it on the basis of *compulsion*. In very sharp contrast indeed, when an industry is private, *voluntary payments* are the order of the day. In the free society, no one forces anyone else to patronize a commercial establishment.

#### References:

Adie, Douglas K. 1990. *The Mail Monopoly: Analyzing Canadian Postal Service*, Vancouver: The Fraser Institute

Adie, Douglas K. 1988. *Monopoly Mail: Privatizing the United States Postal Service*, New Brunswick, N.J.: Transaction

Adie, Douglas K. 1990. “Why Marginal Reform of the U.S. Postal Service Won’t Succeed,” in *Free the Mail: Ending the Postal Monopoly*, Peter J. Ferrara, ed., Washington, D.C.: The Cato Institute

Allen, Hugh. 1943. *The House of Goodyear*. Cleveland: Corday & Cross

Anderson, Gary M. 1987. "Welfare Programs in the Rent Seeking Society," *Southern Economic Journal*, 54: 377-386

Anderson, Martin. 1978. *Welfare: The Political Economy of Welfare Reform in the United States*, Stanford: Hoover Institution

Anderson, William L. 2004. "Health Care in Prison." February 23  
<http://www.mises.org/fullstory.aspx?control=1456>

Baird, Charles. 1980. *Rent Control: The Perennial Folly*, Washington D.C.: The Cato Institute

Barnett, William II, and Michael Saliba. 2004. "A Free Market for Kidneys: Options, Futures, Forward, and Spot." *Managerial Finance*. 30 (5): 38-56.

Barnett, William II and Walter Block. 2006. "On Gallaway and Vedder on Stabilization Policy" *Quarterly Journal of Austrian Economics*. Vol. 9, No. 1, spring, pp. 57-81;  
[http://www.mises.org/journals/qjae/pdf/qjae9\\_1\\_5.pdf](http://www.mises.org/journals/qjae/pdf/qjae9_1_5.pdf)

Block, Walter. 1977. "Coase and Demsetz on Private Property Rights," *The Journal of Libertarian Studies*, Vol. I, No. 2, Spring, pp. 111-115.

Block, Walter. 1986. *The U.S. Bishops and Their Critics: An Economic and Ethical Perspective*, Vancouver: The Fraser Institute.

Block, Walter. 1988. "The Case for a Free Market in Body Parts," in *Murray N. Rothbard: Giant of Liberty*, Walter Block and Llewellyn Rockwell, eds., *Essays in the Economics of Liberty: The Free Market Reader*, Auburn, AL: The Ludwig von Mises Institute; [http://www.mises.org/freemarket\\_detail.asp?control=476](http://www.mises.org/freemarket_detail.asp?control=476)

Block, Walter. 1995. "Ethics, Efficiency, Coasean Property Rights and Psychic Income: A Reply to Harold Demsetz," *Review of Austrian Economics*, Vol. 8, No. 2, pp. 61-126

Block, Walter. 1996. "O.J.'s Defense: A Reductio Ad Absurdum of the Economics of Ronald Coase and Richard Posner," *European Journal of Law and Economics*, Vol. 3, pp. 265-286

Block, Walter. 2001. "Socialized Medicine is the Problem," *Ideas on Liberty*, December;

Block, Walter. 2002. "A critique of the legal and philosophical case for rent control," *Journal of Business Ethics*, Vol. 40, pp. 75-90;  
<http://www.mises.org/etexts/rentcontrol.pdf>

Block, Walter, Joseph Horton and Ethan Shorter. 1998. "Rent Control: An Economic Abomination," *International Journal of Value Based Management*, Vol. 11, No. 3, pp. 253-263

Boettke, Peter J. 1991. "The Austrian Critique and the Demise of Socialism: The Soviet Case," in *Austrian Economics: Perspectives on the Past and Prospects for the Future*. Vol. 17, Richard M. Ebeling, ed., Hillsdale, MI: Hillsdale College Press, pp. 181-232.

Boettke, Peter J. 1993. *Why Perestroika Failed: The Politics and Economics of Socialist Transformation*, London: Routledge

Brown, Arnold. 1987. "The Shadow Side of Affluence: The Welfare System and the Welfare of the Needy," *Fraser Forum*, October.

Butler, Stuart M. 1986. "Privatizing Bulk Mail," *Management*, 6, No. 1

Cordato, Roy E. 1989. "Subjective Value, Time Passage, and the Economics of Harmful Effects," *Hamline Law Review*, Vol. 12, No. 2, Spring, pp.229-244.

Cordato, Roy E. 1992. *Welfare Economics and Externalities in an Open-Ended Universe: A Modern Austrian Perspective*, Boston: Kluwer

Cordato, Roy E. 1997. "Market-Based Environmentalism and the Free Market: They're Not the Same," *The Independent Review*, Vol. 1, No. 3, Winter, pp. 371-386.

Cordato, Roy. 1998. "Time Passage and the Economics of Coming to the Nuisance: Reassessing the Coasean Perspective," *Campbell Law Review*, vol. 20, No. 2, Spring, pp. 273-292

Cordato, Roy. 2000. "Chasing Phantoms in a Hollow Defense of Coase" *The Review of Austrian Economics*, Vol. 13, No. 2, September, pp. 193-208.

Friedman, Milton. 1962. *Capitalism and Freedom*, Chicago: University of Chicago Press

Friedman, Milton. 2001. "How to Cure Health Care." *The Public Interest*. Winter. <http://www.thepublicinterest.com/archives/2001winter/article1.html>

Giles, Chris. 2005. "OECD champions free market recipe." June 7. <http://news.ft.com/cms/s/ecc4161e-d794-11d9-9f43-00000e2511c8.html>

Goodman, John C. and Gerald L. Musgrave. 1992. *Patient Power: Solving America's Health Care Crisis*. Washington D.C.: Cato

Gordon, David. 1990. *Resurrecting Marx: The Analytical Marxists on Freedom, Exploitation, and Justice*, New Brunswick, NJ: Transaction.

Gottfredson, Linda S. 1986. "Societal consequences of the g factor in employment." *Journal of Vocational Behavior*, 29, 379-410.

Grampp, W.S. 1950. "Some Effects of Rent Control," *Southern Economic Journal*, April, pp. 425-426

Gratzer, David. 2005. "The Return of HillaryCare: Socialized medicine is still not a good idea. *The Weekly Standard*. May 23  
[http://www.medicalprogresstoday.com/spotlight/spotlight\\_indarchive.php?id=778](http://www.medicalprogresstoday.com/spotlight/spotlight_indarchive.php?id=778)

Hanke, Steve H., ed., 1987. *Privatization and Development*, San Francisco: Institute for Contemporary Studies

Hamowy, Ronald. 1984. *Canadian Medicine: A Study in Restricted Entry*, Vancouver: The Fraser Institute

Hare, R.M. 1952. *The Language of Morals*. Oxford: Oxford University Press

Hare, R. M. 1963. *Freedom and Reason*. Oxford: Oxford University Press

Hayek, F.A. 1948. "A Commodity Reserve Currency," "Socialist Calculation I, II, & III," *Individualism and Economic Order*, Chicago: University of Chicago Press.

Herbener, Jeffrey. 1996. "Socialized Medicine, Take Two." *The Free Market*. Vol. 14, No. 7, July;  
[http://www.mises.org/freemarket\\_detail.asp?control=172&sortorder=articledate](http://www.mises.org/freemarket_detail.asp?control=172&sortorder=articledate)

Higgs, Robert. 1995. "The Myth of 'Failed' Policies." *The Free Market*. June. Vol. 13, No. 6. [http://www.mises.org/freemarket\\_detail.asp?control=239&sortorder=articledate](http://www.mises.org/freemarket_detail.asp?control=239&sortorder=articledate)

Holcombe, Randall G. 1995. *Public Policy and the Quality of Life*. Westport, CT: Greenwood Press.

Hoppe, Hans-Hermann. 1989. *A Theory of Socialism and Capitalism*, Boston, MA: Kluwer Academic Publishers.

Hoppe, Hans-Hermann. 1991. "De-Socialization in a United Germany," *Review of Austrian Economics*, 5(2), pp. 77-106.

Hoppe, Hans-Hermann. 1996. "Socialism: A Property or Knowledge Problem?" *Review of Austrian Economics*, 9(1), pp. 147-154.

Johnson, M. Bruce, ed. 1982. *Resolving the Housing Crisis: Government Policy, Decontrol, and the Public Interest*, San Francisco: The Pacific Institute

Johnson, Clint, Walter Block and Thomas Oxner. 1998. "Notes on Health Care Financing and Free Markets," *Journal of Accounting, Ethics and Public Policy*, Vol. 1, No. 3, Summer 1998, pp. 488-502.

Kinsella, Stephan. 1992. "Estoppel: A New Justification for Individual Rights," *Reason Papers* No. 17, Fall, p. 61

Kinsella, Stephen. 1996. "Punishment and Proportionality: the Estoppel Approach," *The Journal of Libertarian Studies*, Vol. 12, No. 1, Spring, pp. 51-74;  
[http://www.mises.org/journals/jls/12\\_1/12\\_1\\_3.pdf](http://www.mises.org/journals/jls/12_1/12_1_3.pdf)

Kinsella, Stephan. 2005. "A Libertarian Defense of 'Kelo' and Limited Federal Power." August 28. <http://www.lewrockwell.com/kinsella/kinsella17.html>

Kirzner, Israel M. 1973. *Competition and Entrepreneurship*. Chicago: University of Chicago Press

Kirzner, Israel M. 1988. "The Economic Calculation Debate: Lessons for Austrians," *Review of Austrian Economics*, 2, pp. 1-18

Klein, Peter G. 1996. "Economic Calculation and the Limits of Organization" *Review of Austrian Economics*, 9(2), pp 3- 28;

Krauss, Michael. 1999. "Tort Law, Moral Accountability, and Efficiency: Reflections on the Current Crisis" *Markets and Morality*, Vol. 2, No. 1, Spring.  
[http://www.acton.org/publicat/m\\_and\\_m/1999\\_spr/krauss.html](http://www.acton.org/publicat/m_and_m/1999_spr/krauss.html)

Krecke, Elisabeth. 1996. "Law and the Market Order: An Austrian Critique of the Economic Analysis of Law," *Journal des Economistes et des Etudes Humaines* 7(1), March, pp.19-37

Krugman, Paul. 2004. "The Health of Nations." *The New York Times*. Feb 17.  
<http://query.nytimes.com/gst/abstract.html?res=F7081FFB3F590C748DDDAB0894DC404482>

Krugman, Paul. 2005. "Ailing Health Care." *The New York Times*. April, 11.  
[http://www.truthout.org/docs\\_2005/printer\\_041105H.shtml](http://www.truthout.org/docs_2005/printer_041105H.shtml)

Krugman, Paul. 2005. "Passing the Buck." *The New York Times*. April, 22.  
<http://www.nytimes.com/2005/04/22/opinion/22krugman.html?ex=1271822400&en=c801ae54c0a01618&ei=5090&partner=rssuserland&emc=rss>

Krugman, Paul. 2005. "Ailing Health Care." *New Orleans Times Picayune*. April, 30.

Krugman, Paul. 2005. "One Nation, Uninsured." *The New York Times*. June 13.  
<http://www.nytimes.com/2005/06/13/opinion/13krugman.html?ex=1119326400&en=72d5ecd649fa3662&ei=5070&emc=eta1>

LaBletta, Nicole and Walter Block. 1999. "The Restoration of the American Dream: A Case for Abolishing Welfare," *Humanomics*, Vol. 15, No 4, pp. 55-65

Lincoln, G.A., W. T. Smith, and J. B. Durst. 1961. "Mobilization and War," in Seymour E. Harris, ed., *American Economic History*, New York: McGraw Hill Book Co.

Lindbeck, Assar. 1972. *The Political Economy of the New Left*, New York: Harper and Row

McGee, Robert, and Block, Walter. 1994. "Pollution Trading Permits as a Form of Market Socialism, and the Search for a Real Market Solution to Environmental Pollution," *Fordham University Law and Environmental Journal*, Vol. VI, No. 1, Fall, pp. 51-77

Mises, Ludwig von. 1969. *Bureaucracy*, New Rochelle, N.Y.: Arlington House

Mises, Ludwig von. 1975[1933]. "Economic Calculation in the Socialist Commonwealth," in Hayek, F.A., ed., *Collectivist Economic Planning*, Clifton, N.J.: Kelley

Mises, Ludwig von. 1981 [1969]. *Socialism*, Indianapolis: Liberty Fund

Moore, Stephen and Stuart Butler, eds., 1987. *Privatization*, Washington: Heritage Foundation.

Moore, Thomas G. 1990. "The Federal Postal Monopoly: History, Rationale, and Future," *Free The Mail: Ending the Postal Monopoly* ed. Peter J. Ferrara. Washington, D.C.: CATO Institute

Moore, Stephen. 1987. "Privatizing the U.S. Postal Service," in Stephen Moore and Stuart Butler, eds., *Privatization*, Washington: Heritage Foundation.

Murray, Charles. 1984. *Losing Ground: American Social Policy from 1950 to 1980*, New York: Basic Books

Myrdal, Gunnar. 1965. "Opening Address to the Council of International Building Research in Copenhagen"; cited in *Dagens Nyheter* (Swedish Newspaper), 25 August 1965, p. 12

North, Gary. 1992. *The Coase Theorem*, Tyler, Texas: Institute for Christian Economics

Nozick, Robert. 1974. *Anarchy, State, and Utopia*, New York: Basic Books

Olasky, Marvin. 1992. *The Tragedy of American Compassion*, Chicago: Regnery Gateway

Poole, Robert. 1976. *Cutting Back City Hall*, New York: Reason Press

- Posner, Richard A. 2003. *Public intellectuals: a study of decline*. Cambridge: Harvard University Press
- Priest, George. 1975. "The History of the Postal Monopoly in the United States," *Journal of Law and Economics*, Vol. 18, No. 33, pp. 33-80
- Rawls, John. 1971. *A Theory of Justice*, Cambridge: Harvard University Press
- Reinhardt, Uwe E., Peter S. Hussey and Gerard F. Anderson. 2004. "U.S. Health Care Spending In An International Context" *Health Affairs*, Vol. 23, No. 3, pp. 10-25;  
<http://content.healthaffairs.org/cgi/content/abstract/23/3/10>
- Rockwell, Jr., Llewellyn H. 2000. "Subsidizing Sickness." October 26.  
<http://www.lewrockwell.com/rockwell/sickness.html>
- Rothbard, Murray N. 1971. "Lange, Mises and Praxeology: The Retreat from Marxism." *Toward Liberty*. Vol. II, Menlo Park, CA: Institute for Humane Studies, pp. 307-321.
- Rothbard, Murray N. 1976. "Ludwig von Mises and Economic Calculation Under Socialism," Moss, Laurence S., ed., *The Economics of Ludwig von Mises*, Kansas City: Sheed & Ward, pp. 67-77
- Rothbard, Murray N. 1982. "Law, Property Rights, and Air Pollution," *Cato Journal*, Vol. 2, No. 1, Spring
- Rothbard, Murray N. 1991. "The End of Socialism and the Calculation Debate Revisited," *Review of Austrian Economics*, 5(2), pp. 51-70.
- Rothbard, Murray N. 1997 [1956]. "Toward a Reconstruction of Utility and Welfare Economics." *The Logic of Action* Vol. I. Lyme, NH: Edward Elgar. pp. 225-227
- Rothbard, Murray N. 1998 [1982]. "Welfare and the Welfare State." *The Ethics of Liberty*, Atlantic Highlands, N.J.: Humanities Press, pp. 160-193;  
<http://www.mises.org/rothbard/ethics/ethics.asp>
- Salerno, Joseph T. 1990. "Postscript: Why a Socialist Economy is 'Impossible'," in *Ludwig von Mises, Economic Calculation in the Socialist Commonwealth*, Auburn, AL: Ludwig von Mises Institute, pp. 51-71.
- Salerno, Joseph. 1995. "A Final Word: Calculation, Knowledge and Appraisalment," *Review of Austrian Economics*, Vol. 9, No. 1, pp. 141-142;  
[http://www.mises.org/journals/rae/pdf/rae9\\_1\\_8.pdf](http://www.mises.org/journals/rae/pdf/rae9_1_8.pdf)
- Salins, Peter D. 1980. *The Ecology of Housing Destruction: Economic Effects of Public Intervention in the Housing Market*, New York: New York University Press.

- Savas, E. S. 1987. *Privatization*. Chatham, N.J.: Chatham House Publishers.
- Savas, E. S. 2000. *Privatization and Public – Private Partnerships*. Chatham, N.J.: Chatham House Publishers.
- Shapiro, Fred R. 1996. “The Most-Cited Law Review Articles Revisited”, *Chicago-Kent Law Review*, vol. 71
- Smith, Adam. 1776/1965. *An Inquiry into the Nature and Causes of the Wealth of Nations*, New York: Modern Library
- Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic Books
- Steele, David Ramsay. 1981. "Posing the Problem: The Impossibility of Economic Calculation Under Socialism," *The Journal of Libertarian Studies*, Vol. V, No. 1, Winter, pp. 7-22; [http://www.mises.org/journals/jls/5\\_1/5\\_1\\_2.pdf](http://www.mises.org/journals/jls/5_1/5_1_2.pdf)
- Terrell, Timothy D. 2003. “Socialized Medicine in America.” *The Free Market*. Vol. 23, No. 11, November.  
[http://www.mises.org/freemarket\\_detail.asp?control=458&sortorder=articledate](http://www.mises.org/freemarket_detail.asp?control=458&sortorder=articledate)
- Tucker, William. 1984. “Black Family Agonistes,” *The American Spectator*, July, pp. 14-17.
- Tucker, William. 1990. *The Excluded Americans: Homelessness and Housing Policies*, Washington D.C.: Regnery Gateway
- U.S. Constitution. 1787.  
<http://www.law.cornell.edu/constitution/constitution.overview.html>
- White, Lawrence H., 1978, "Privatization of municipally-provided services," *The Journal of Libertarian Studies*, Vol. 2, No. 2, Summer, pp. 187-197
- Worstell, Tim. 2005. “Paul Krugman Sets Us Up as Patsies.” April 11.  
[http://timworstell.typepad.com/timworstell/2005/04/paul\\_krugman\\_se.html](http://timworstell.typepad.com/timworstell/2005/04/paul_krugman_se.html)

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<sup>2</sup> His critics include Anderson, 2005, Gratzner, 2005, Worstall, 2004.

<sup>3</sup> Even the left wing OECD recently argued in favor of competition. See Giles, 2005.

<sup>4</sup> For a similar analysis, only from a Canadian perspective, see Hamowy, 1984.

<sup>5</sup> An English-speaking doctor could then ask and receive answers to questions such as, “Is it a sharp pain or a chronic one?” “For how long had you had this pain?” “What did you eat, recently?” But which would you rather have, gentle reader? A doctor who could not speak English, or none at all?

<sup>6</sup> There are some who deny this on the ground that each new doctor accounts for, or even creates, additional patients and hence more illness. But this is putting the cart before the horse. Yes, each new practitioner takes care of more ill people, but he does so more *cheaply* since price falls as supply rises. This is one of the most basic elements in all of economics: downward sloping demand curves.

<sup>7</sup> I *infer* this from the fact that doctors’ salaries are a large multiple of those who, were entry restrictions into medical practice non-existent, would likely enter the field: people with Ph.D. degrees in biology is my proxy variable in this regard.

<sup>8</sup> Without competition, postal delivery and health care are more and more coming to resemble one another. For more on the post office and the need for competition and privatization there, see Adie, 1990, 1988, 1990; Butler, 1986; Moore, T., 1990; Moore, S., 1987; Priest, 1975.

<sup>9</sup> For a history of medical institutions see <http://www.ebri.org/facts/0302fact.htm>;  
<http://www.eh.net/encyclopedia/?article=thomasson.insurance.health.us>;  
<http://www.reason.com/0411/fe.rb.mandatory.shtml>; <http://www.pbs.org/healthcarecrisis/history.htm>;  
<http://www.ncpa.org/bg/bg154/bg154.html>; <http://www.nchc.org/facts/cost.shtml>;  
[http://www.manhattan-institute.org/pdf/PI\\_gratzer\\_spring05.pdf](http://www.manhattan-institute.org/pdf/PI_gratzer_spring05.pdf);  
I owe these cites to John Kyle

<sup>10</sup> I owe this point to Mike Golden.

<sup>11</sup> This is similar to Murray (v Caplan) saying not that government decreases welfare, but that it can never be shown to increase it.

<sup>12</sup> This issue has been the subject of a debate between Nozick (1974) and Rawls (1971). The latter offers his “difference principle” according to which any economic act may properly occur that enriches the wealthy, provided only that it also benefit the poor. He claims that if there were a “veil of ignorance” (none of us knew the roles we would play in the real world) we would all choose this economic system; therefore it is justified. The former criticizes this concept with his “Wilt Chamberlain” example: any such egalitarian scheme falls victim to the fact that voluntary exchanges (lots of people, including the impoverished, pay to see Wilt dunk a basketball) will have to be rescinded, and thus Rawls’s thesis is incompatible with economic freedom. It is my view that we can use the insights of Hare (1952, 1963) to support the Nozick perspective, vis a vis that of Rawls. Hare is known for two philosophical principles, universalizability and prescriptivity. According to the first, moral judgments are general principles: they apply to everyone. According to the second, people ought to act in accordance with their ethical judgments. How does this apply to the present case? Rich Rawlsians, or socialists, among whom there are many on university faculties, are acting illogically. On the one hand, they preach egalitarianism; on the other, they have far

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more wealth than the poor, even than those at the mean. Thus, they are logically estopped (Kinsella, 1992, 1996) from making their claims.

<sup>13</sup> Exacerbating this situation is the fact that there are not enough emergency rooms available, also due to governmental restrictions on entry. A “certificate of need” is required to set up new ones. State boards of health and commission on accreditation of hospitals determine such needs. As a result, there is little or no competition between hospitals. There are also further restrictions on entry into the sub specialties such as cardio thoracic surgery. I owe these points to Mike Golden. Imagine the lack of competition if “certificates of need” were required before one could set up a grocery or newsstand.

<sup>14</sup> This would account for the need for higher IQs on the part of doctors (Gottfredson, 1986, 400-401) and additional years of investment in training.

<sup>15</sup> We must of course be ever vigilant not to commit the diamond – water paradox fallacy. We never pick between *all* food, clothing, shelter, medical care, etc., but only make such choices at the margin.

<sup>16</sup> When Hilary Clinton spoke of a vast right wing conspiracy (<http://members.shaw.ca/trogl/vast.html>), she did not have the medical profession in mind. She should have.

<sup>17</sup> There is, of course, such a thing as homeowners’ insurance. But, that is for people who *already have* a house, and want to protect themselves against its loss. Here, we are making an analogy to medical insurance. When applied to the housing market, it translates into purchasing insurance against *not being able to purchase* a home, and, there is no such thing at present.

<sup>18</sup> Clint Johnson emphasized this point to me.

<sup>19</sup> <http://www.newswire.ca/en/releases/archive/June2005/09/c0166.html>;  
<http://www.nytimes.com/2005/05/21/international/americas/21chaoulli.html?ex=1274328000&en=55183310e5999477&ei=5088&partner=rssnyt&emc=rss>

<sup>20</sup> Here is part of what the Wall Street Journal (6/13/05) had to say about this case: “Let’s hope Hillary Clinton and Ted Kennedy were sitting down when they heard the news of the latest bombshell Supreme Court ruling. From the Supreme Court of Canada, that is. That high court issued an opinion last Thursday saying, in effect, that Canada’s vaunted public health-care system produces intolerable inequality.” (<http://www.opinionjournal.com/editorial/feature.html?id=110006813>)

<sup>21</sup> Krugman (6/13/05) is evidently unaware of this recently publicly exposed (but existing for a long duration) debacle of Canadian health insurance, as he is still at the same lemonade stand, peddling his socialist medical care nostrums.

<sup>22</sup> For a brief history, see [http://en.wikipedia.org/wiki/Health\\_insurance#History\\_and\\_evolution](http://en.wikipedia.org/wiki/Health_insurance#History_and_evolution). I owe this cite to my Loyola University New Orleans colleague William Barnett II.

<sup>23</sup> According to Lincoln, Smith and Durst (1961, 227): “The program of price control and rationing of civilian items under the Office of Price Administration was inseparable from the problems of wages and wage control.” I owe this cite to my former University of Central Arkansas colleague Clint Johnson.

<sup>24</sup> Eleemosnery charitable institutions such as the Benevolent and Protective Orders of Elks, Odd Fellows and Moose, etc. were active in this role, as well as were various religious groups. Some business firms sponsored private health care programs, for example, the Goodyear Relief Association (Allen, 1943; Holcombe, 1995; Starr, 1982). I owe the first of these cites to Dave Garthoff and the last to Randy Holcombe.

<sup>25</sup> I owe this point to William Barnett II.

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<sup>26</sup> See Galloway and Vedder (1992, 154). For a critique of this book, albeit on entirely other grounds, see Barnett and Block, 2006.

<sup>27</sup> This phrase is a redundancy.

<sup>28</sup> We are discussing reasonably big-ticket items, here. There is little doubt that the practice of a firm buying its employees doughnuts and coffee, or giving them a picnic, or rewarding them with pizza and beer for a job well done, or subsidizing their lunches will long endure. These are ways of building up esprit de corps, or eliciting additional work out of them for the same pay, as when lunch in the company dining room saves significant travel costs, so workers do not wander too far afield during these times.

<sup>29</sup> <http://www.gao.gov/new.items/d03702.pdf#search='Medical%20malpractice%20insurance%20rates'>; <http://www.virginiamahan.com/column40.html>; <http://www.insurance-reform.org/StableLosses.pdf#search='medical%20malpractice%20rates'>

<sup>30</sup> Many of the points in this section were made to me by John Morgan.

<sup>31</sup> It is called, not too surprisingly, law and economics.

<sup>32</sup> For critiques of Coase (1960), see Block (1977, 1995, 1996), Cordato (1989, 1992, 1997, 1998, 2000), Krause (1999), Krecke (1996), North (1992) and Rothbard (1982)

<sup>33</sup> For the Austrian views on socialism, see Boettke, 1991, 1993; Gordon, 1990; Hoff, 1981; Hoppe, 1989, 1991, 1996; Kirzner, 1988; Klein, 1996; Mises, 1975, 1981; Rothbard, 1971, 1976, 1991; Salerno, 1990, 1995; Steele, 1981, 1992.

<sup>34</sup> Although see *KELO et al. v. CITY OF NEW LONDON et al.* certiorari to the Supreme Court of Connecticut; No. 04-108. Argued February 22, 2005--Decided June 23, 2005 <http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=US&navby=case&vol=000&invol=04-108>; see also Kinsella, 2005.

<sup>35</sup> One must take this with a grain of salt, since the FDA perverts drug prices, which are an important input into this industry.

<sup>36</sup> It might be argued that it is unfair, or improper, to devote an entire article in a scholarly journal such as *This One* merely to counteract a (series of) newspaper column(s). Why should the present author not be limited to the 800 words utilized by Krugman in his columns? And what is with these footnotes? Surely, this is overkill? The case on the other side consists of the fact that Krugman is not only a public figure (Posner, 2003, 38, 96-99, 101-103, 105, 138, 141, 173, 402), this Princeton professor is nobelabile in economics; (“papabile” refers to a cardinal who has a reasonable chance of becoming pope; nobelabile to an economist likely to win the Nobel Prize.) After all, he has already won the John Bates Clark Award (in 1991 - [http://en.wikipedia.org/wiki/Paul\\_R.\\_Krugman](http://en.wikipedia.org/wiki/Paul_R._Krugman)) for best economist under the age of 40, a listing that somewhat reliably predicts the later triumph in the Nobel sweepstakes (<http://www.westga.edu/~bquest/2003/sept10.htm>). Further, these articles appeared in the *New York Times*, certainly one of the at least so far successful newspapers in the world. In addition, it often takes more space to demonstrate why a fallacious argument is wrong than merely to state it.

<sup>37</sup> One may forgiven for thinking this latter estimate way too low.

<sup>38</sup> Dr. Jane Orient (letter to the present author, 6/28/05) refers to the: “... absurdity of running small claims through a third party... So the right comparison to be made is not between the total hypothetical costs of a single-payer system versus the ‘managed care’ system that we have now, but ... between a system that is bureaucratized from top to bottom and the old-fashioned system now seen in every grocery store and an occasional physician’s office. It’s not as though we haven’t tried this before. Only 30 years ago, this was the predominant method of paying for medical services.” I would add that this would, again, be the

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predominant method of paying for medical services if the state were to separate itself from the medical industry, and allow free enterprise to once again take hold in that sector of the economy.

<sup>39</sup> Krugman posits that private enterprise has higher administrative costs than governmental. This is at variance with numerous findings that the latter is usually a multiple of the former. See on this Hanke, 1987; Moore and Butler, 1987; Poole, 1976; Savas, 1987, 2000; White, 1978.

<sup>40</sup> Reading in between the lines, it appears that Krugman's ideal health care system would be something similar to what prevails in Canada. However, Canada has fallen far behind the U.S. in terms of the enjoyment of modern medical technology, patients north of the border suffer on long waiting lists for service that are simply unknown south of the border, there are great inequities in this regard as politicians, sports figures, Americans and even *pets* can often jump the Canadian queue. See on this: <http://www.ncpa.org/bg/bg129.html>

<sup>41</sup> Similarly, students with high grades are offered lower rates on car insurance, on the ground that they are less likely to end up in a motor vehicle accident.

<sup>42</sup> In private insurance, companies that do not do this at all, or that misperceive the true risks and attendant costs, tend to go bankrupt, making way for firms that can fulfill this function more accurately. When the state provides "insurance," no such tendency occurs.

<sup>43</sup> Of course, the very definition of insurance has been perverted by these governmental incursions. Once again we call upon Friedman (2001) to explain: "Employer financing of medical care has caused the term 'insurance' to acquire a rather different meaning in medicine than in most other contexts. We generally rely on insurance to protect us against events that are highly unlikely to occur but involve large losses if they do occur . . . . We insure our houses against loss from fire, not against the cost of having to cut the lawn . . . Yet in medicine, it has become common to rely on insurance to pay for regular medical examinations and often for prescriptions." I owe a great debt of gratitude to Valentin Petkantchin for pointing out this cite to me.

<sup>44</sup> That is, this would occur on the free market. In the event, charging higher prices to homosexuals who engage in dangerous sexual practices would nowadays likely be construed as in violation of one of a plethora of "hate" laws. There is a similar situation that prevails with regard to several of the other criteria. Lower rates for younger people can be interpreted as "ageism," and higher prices for the obese as discrimination against the handicapped. Only smokers are fair game, for reasons that exceedeth the imagination.

<sup>45</sup> There are recalls for tires, wiring, brakes, etc. Why not Ph.D.s too?

<sup>46</sup> This is due in turn, as we have seen, to restrictions on entry into medical practice, and moral hazard, see *infra*.

<sup>47</sup> Any one who thought that the money emanating from charitable motives toward these ends was insufficient would be free to step up his rate of giving.

<sup>48</sup> Yes, of course, there are government welfare programs. But the poor do as well as they do in *spite* of these initiatives, not because of them. On this see Anderson, G., 1987; Anderson M., 1978; Brown, 1987; Higgs, 1995; LaBletta and Block, 1999; Murray, 1984; Olasky, 1992; Rothbard, 1998; Tucker, 1984;

<sup>49</sup> Krugman's attack on administrative costs is reminiscent of other socialist economists in their condemnation of advertising or selling costs. In the view of the latter, costs undertaken for production are legitimate, but those dedicated to marketing are not. This is an entirely misbegotten view of economics. Unless and until the product is brought to the final consumer, it might as well not have been produced at all, as far as the latter is concerned. What is the good of *producing* shoes or cars, if they are not made available to the consumer, and this can never occur unless the product is actually *sold*, and this cannot take place in the absence of selling costs such as marketing or advertising? For more on this see Kirzner, 1973.

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<sup>50</sup> According to that old joke, “Do you know the difference between a bathroom and a living room?” If the answer is “No,” then the reply is “Well, don’t come to my house, then.” In similar manner we may now say, and this is no joke, that if you cannot distinguish between a voluntary payment and a coercive one, then do not enter into the realm of political economy.

<sup>51</sup> Another redundancy.

<sup>52</sup> With the exception of housing in places like New York City that still have rent control laws. For a critique of this legislation, see Baird, 1980; Block, Horton and Shorter, 1998; Block, 2002; Grampp, 1950; Johnson, 1982; Lindbeck, 1972; Myrdal, 1965; Salins, 1980; Tucker, 1990

<sup>53</sup> For a critique, see (Block, 2001; Rockwell, 2000).

<sup>54</sup> This would include a free market in blood, organs, and other used body parts. For a defense of this “modest proposal” see Barnett and Saliba, 2004; Block, 1998; Goodman and Musgrave, 1992; Hamowy, 1984; Herbener, 1996; Johnson, et al., 1998; Laydon and Block, 1996; Terrell, 2003.

<sup>55</sup> Certainly, no more statist interference with medical care than with paper clips, ink toner or rubber bands.

<sup>56</sup> Is full free enterprise in this industry politically feasible? Not at all. But this is entirely irrelevant. It is unlikely in the extreme that all people will in the immediate future renounce cigarette use. Yet, this cannot demonstrate that if they did, they would be healthier. In the same way, our medical access problems would end in one fell swoop were we to implement the proposals outlined herein, *despite* the fact that such a course of action is not to be realistically expected.

<sup>57</sup> For a critique of market socialism in a different context, see McGee and Block, 1994.

<sup>58</sup> For a description of the health services afforded U.S. prisoners, see Anderson, 2005.

<sup>59</sup> It is not surprising that socialized medicine should not be mandated by the U.S. Constitution (1787). Indeed, it was the bed rock of U.S. presidential candidate Dr. Ron Paul (<http://www.house.gov/paul/>) that such measures should not be undertaken for precisely this reason. It was drawn up during a more laissez faire epoch than at present. However, not even the far more modern *Helsinki Principles of Human Rights* (1975) requires programs of this sort.