THE FREEMAN
IDEAS ON LIBERTY

A Sales Pitch for Laissez-Faire Health Care

by Daniel B. Klein

What would it mean to establish liberty of property, consent, and contract in the area of health care?

It would mean the repeal of FDA drug-approval requirements, prescription laws, drug-development regulations, and restrictions on the dissemination of information. It would mean the repeal of state and local regulations in the following areas: medical schools and hospitals, occupational licensure, diagnosis and referral, the employment of doctors by for-profit firms, nonphysician ownership of medical firms, the use of brand names, the operation of multiple branch offices, the location of health-care facilities, and marketing practices. For prepaid health plans and hospitals, it would mean the repeal of regulations on benefit packages, enrollment requirements, rate setting, and facility expansion.[1]

Here I speculate on the desirable features of such a regime.

Education and Training of Practitioners: Private and public institutions would issue degrees, certificates, and other credentials to candidates meeting their requirements. Many training programs would be intensive programs for specific skills. Training would expand and diversify drastically, perhaps even reaching down to basic training for lay people. The profile of practitioners would thus expand. It would permit practitioners the flexibility to adapt their human capital to the opportunities of time and place. Costs to the consumer would drop considerably. To make sense of this blossoming of health services, people would rely on knower-intermediaries, information disclosures, brand names, and so on.

Drug Development and Availability: Costs would plummet, timeliness would improve and the profile of drugs would expand. Strong safety and quality incentives would flow from the umbrella of the pharmaceutical brand name and the tort system. Knower-institutions—perfectly analogous to Underwriters' Laboratories—would develop to certify safety. Doctors and pharmacists, acting as knowers and middlemen, would use their expert knowledge of drugs in advising the consumer.

The market would serve as an experimentation process—sometimes people would be killed by unsafe drugs (and companies would pay dearly), but such consequences belong to a benign process. There is a saying for people who frequently use air travel: If I never miss a plane I know I'm spending too much time in airports. At present, the FDA is the Chauffeur whose pre-eminent incentive is to get the passenger to the airport on time. The consequence is that it gets us to the airport three days before the flight, and charges us dearly for the ride. The deaths of 100 children from Sulfanilamide in 1938 pale when compared with the annual death toll from the FDA's curtailment of drug availability. One study catalogues 192 generic and 1,535 brand-name tested drugs available abroad but not approved for sale in the United States.[2] How many thousands of deaths per year does such delay cause? Sam Kazman of the Competitive Enterprise Institute estimates that the FDA delay of just two drugs, misoprostol (which reduces gastric ulcers) and streptokinase (which dissolves blood clots in heart-attack victims), has caused thousands of deaths.[3]

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Information and the Active Patient: Drug information would be improved by freedom to self-disclose in labeling and advertising. At present, consumer access to medical information is expanding, in the forms of health-care literature, medical libraries, online information services like Internet, referral services like Prologue, and services like The Health Resource, which generates for a fee thick packets of medical literature to customers specifying a diagnosis.[4] In a freer market consumers would have easier access to opportune and pointed knowledge.

Commercialization: Brand-name and franchised clinics, medical groups, hospitals, and insurance plans would flourish. Milton Friedman prophesied in 1962: "[T]hey could organize medical care efficiently, combining medical men [and women] of different degrees of skill and training, using technicians with limited training for tasks for which they were suited, and reserving highly skilled and competent specialists for the tasks they alone could perform."[5] Consumers would obtain at low cost gatekeeper diagnosis, referral, and second-opinion. Friedman's early vision of "department stores of medicine" would be proven prophetic.

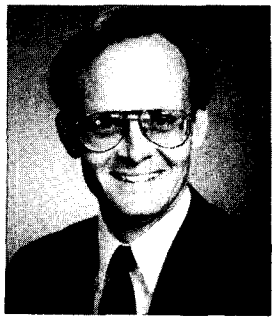
Medical Groups and Insurance: Currently, medical groups employ utilization review and peer monitoring to police quality. Intermediaries (such as employers, membership organizations, and so on) serve as middlemen and agents, shopping over medical plans, helping large sets of ignorant consumers discriminate between better and worse health care. In a regime of freedom *and enforcement* of contract, health plans and insurers could write better patient-enrollment contracts and patient-performance contracts. They could mitigate member-selection problems by using more refined screening and pricing techniques. Perhaps firms would emerge to research, compile, and verify individuals' medical histories. Health plans and insurers could mitigate moral-hazard problems by requiring flu shots, check-ups, and other programs to promote prevention and early treatment.

Independent Knower Organizations: Data banks, consumer information bureaus, referral services, reporting literature, drug-testing facilities, and auditing firms would evolve more swiftly. Local organizations would emerge to rate health-care providers through undercover monitoring, patient interviews, or treatment reviews. Such a service might be supported by patients, analogous to *Consumer Reports*, or by physicians, analogous to Underwriters' Laboratories or Moody's. Consumers would reward those organizations that help them assess credentials and discriminate among the array of available health services.

Lay Awareness: There would be medical education without sacerdotal restraints. Basic medicine could be part of the high school curriculum. All manner of health-care education and training could be offered in community colleges and private institutes. Entrepreneurs have already developed medical software that responds to a list of symptoms with possible diagnoses and treatments.[6] This program is based on data that are more extensive, more accurate, and more current than any doctor could hope to command. Informal courses might teach lay people how to use such programs. People would have better information to assess their needs and opportunities, and they would have the power to self-medicate.

In 1963, the famed economist Kenneth Arrow could write: "It is the general social consensus, clearly, that the *laissez-faire* solution for medicine is intolerable."[7] Nowadays there is no such general social consensus. □

1. Paul J. Feldstein, *Health Care Economics*, 4th ed., Albany: Delman Pub., 1993, p. 321.
2. Kenneth Anderson and Lois Anderson, eds., *Orphan Drugs* (Los Angeles: The Body Press), 1987.
3. James Bovard, "Double-Crossing to Safety," *The American Spectator*, January 1995, pp. 24–29.
4. Brigid McMenamin, "An Educated Consumer Is Her Best Patient," *Forbes*, June 21, 1993, p. 118.
5. Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962).
6. Stephen S. Hyde, "The Last Priesthood: The Coming Revolution in Medical Care Delivery," *Regulation*, Fall 1992, pp. 70–74.
7. Kenneth J. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review*, 53, December 1963, p. 967.



Block Grants Are Not the Answer

If you want something done in your community, would it ever occur to you to send a check to Washington, D.C., first, so that the federal bureaucracy could take a cut before sending back the rest?

Welcome to the new world of "block grants"—the latest fashion that has Congress and state legislatures buzzing. The motivation is commendable: reduce federal micromanagement and allow states to innovate by giving them large dollops of federal money with few strings attached. In place of failed, one-size-fits-all programs run rigidly by Washington, the states would function as 50 "laboratories," generating new approaches that would work better because states are closer to the people. Congress, before the year is out, may reorganize and consolidate many federal programs this way—from welfare to crime control.

The block grant idea per se is not really new, but now the Congress is moving toward implementing it in a massive way. Less than 20 percent of the $200 billion Washington sends back to the states now goes in the form of block grants, and all of that went for operating or capital expenses for local or regional projects. The congressional leadership now wants to take the next step and convert "entitlement" programs into block grants. These are programs whose spending requirements are determined not by some fixed appropriation the Congress decides it wants to make, but by the "needs" of those whom the law says are "entitled" to the cash. Welfare-state proponents argue that without an automatic entitlement written into the law, the amount the federal government sends to the states may prove insufficient to meet the "needs" of all the people who qualify for the programs.

The states respond by saying, "Give us the money without all the expensive and ridiculous mandates and rules and we'll make enough savings to do at least as good a job for even less money." All other things equal, they're probably right, but that's not the end of the story.

If less federal meddling in how programs are locally run is the primary objective of the block-grant approach, it may be easy to achieve at the start but difficult to sustain. As the old saying goes, "He who pays the piper calls the tune." Congress will always be tempted to add conditions and clarifications each time appropriations bills containing block grants come up. It is not hard to imagine state and local officials complaining, a few years from now, "Where did all these strings come from?"

The truth is that block grants would do little to address the inherent flaws in our current system of multi-layered bureaucratic structures. Laundering the people's money through two or three levels of government is a make-work scheme for administrators. One study showed that, of the

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