BRIEFING PAPER:

THE LIBERTARIAN PARTY'S HEALTH CARE PROPOSAL

A free market alternative
for health care reform

PROJECT HEALTHY CHOICE

The Libertarian Party's Alternative
Free Market Health Care Proposal

Introduction

Fact: Our current system of health care in the United States is not working. Too many Americans have too little access to affordable health care; health insurance costs are skyrocketing; and government health programs are running grossly over projected expenses.

Fact: The proposed Clinton health care "reform" plan will only make things worse. It is a mind-bogglingly complex stratagem devised by "policy wonks" that will allow government bureaucrats to take over one-seventh of the U.S. economy — and allow them to intrude into the most personal doctor-patient relationships. It will also increase the already onerous tax burden borne by hard-working Americans.

What is the alternative?

It's simple: What Americans need now is a new way of looking at health care, and a new blueprint for an affordable, convenient, sensible health care system.

The Libertarian Party's "Alternative Free Market Health Care Proposal" is that blueprint. It is a plan for pragmatic health care reform that can solve America's current problem — and provide accessible, reasonably priced health care for a vast majority of Americans as we move into the 21st Century.

Drawing on the strength of our nation's free market system, our plan broadens consumer choice, opens up the medical field to more competition, relieves employers of the crushing burden of out-of-control health care insurance premiums — and does all this without the need for new taxes.

But don't just take our word for it. *We can prove it.*

In the pages that follow, we outline the *exact reasons* why the Clinton plan won't work — and we provide the statistics and examples to back up that claim.

Then we present the Libertarian alternative — and we provide the case studies and the numbers to prove that it is a **workable, practical, *fair*** plan. Further, we show how our five-step program will expand coverage, increase choice, make health care more affordable, save lives, and save money.

The result? Better, cheaper, more accessible health care for all Americans — rich and poor.

The Libertarian Party's Alternative Free Market Health Care Proposal: It's a healthy choice for a free and prosperous America!

—The Project Healthy Choice Task Force

Special thanks to Michael Tanner, without whom Project Healthy Choice would not have been possible.

The Clinton Plan

At the heart of President Clinton's proposals for health care reform is a concept known as "managed competition." The concept is the brain child of the "Jackson Hole Group," an ad hoc coalition of health care executives and academic specialists, led by Dr. Paul Elwood.[1]

As envisioned under the President's proposals, each state would establish one or more Health Alliances, which would act as collective purchasing agents on behalf of employers and individuals.[2] All Americans would be enrolled in a Health Alliance, either through their employer or individually.[3] The Alliance would negotiate with certified health Plans for a benefits package on behalf of its members, operating much like German sickness funds.[4] The government would establish a Guaranteed National Benefits Package, effectively determining what benefits will and will not be included in any policies offered. Ultimately, individuals would be able to choose from three government-defined insurance plans. The lowest cost of these would be a managed care plan. Traditional fee-for-service plans, which allow a full choice of physicians, may be available, but would be much higher priced. Certified health plans partnerships would be required to community rate all members of the Alliance and to guarantee coverage to all Alliance members. Every American will receive a "health security card" as a symbol of his now guaranteed health coverage.[5]

Employers would be required to provide coverage for all employees, both full-time and part-time. Employers must pay at least 80% of the cost of coverage, with the employee paying 20%. The employer's premium payment would be capped at 7.9% of an employee's wages for most businesses. However, some very small businesses could have their premiums capped at 3.9% of wages. Nonemployed people with incomes and the self-employed would also have to pay a tax. The federal government would subsidize insurance purchases by those not covered through an employer and unable to pay the full insurance cost themselves.[6]

Public programs, such as Medicaid, would have the option of purchasing care through an Alliance.[7]

A global budget would be established and premium caps would be imposed on the certified health plans, in the hopes of using them to indirectly impose price restraints on hospitals and physicians.

The program would be overseen by a new federal agency, The National Health Board. This would be an independent agency, "similar to the SEC," removed from day-to-day oversight by Congress or the Executive Branch, with broad powers, including "stand-by" authority to impose more direct price controls.

However, as legal economist Richard Epstein has noted, "[Managed Competition] is not so much a coherent government plan as an oxymoron. It is possible to have either managed health care or to have open competition in health care services. It is not possible to have both simultaneously."[8] As proposed, managed competition appears to offer a great deal of management and very little competition. Often discussed as a compromise between various health care reform proposals, managed competition borrows many of the worst elements of other proposals.

As Alain Enthoven, one of the leading proponents of managed competition admits, it is not "a free market system."[9] He is certainly correct about that.

First, the mandate that employers provide health benefits for all full-time employees will cost jobs. The Jackson Hole Group admits that "employer mandates are a form of employment tax."[10] They claim, however, that their explicit taxes would be "fairer" than the current system of allocating costs. But, the real result of such a tax increase is likely to be lost jobs.

The amount of compensation each worker receives for his or her work is directly related to that worker's productivity. Mandating an increase in that compensation by requiring the employer to provide health insurance does nothing to increase productivity. Thus one of two things happens: either 1) consumers must pay higher prices for products; or 2) more likely in a competitive economy, employers will be forced to reduce their payroll costs to offset these new and increased costs of health benefits. Payroll reductions may take several forms. One is a reduction in cash compensation, which in practice is unlikely. More probable is a reduction in the number of employees, either through layoffs or by postponing the hiring of new workers. In either case, unemployment increases, especially among low-skilled workers for whom mandated health benefits constitutes a relatively large increase in employee compensation.[11]

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[1] Elwood and Etheredge, *The 21st Century American Health System*, September 3, 1991.
[2] Health Security Act, Subtitle D
[3] Id., Section 1001-1002, 1601
[4] For a discussion of German Sickness Funds see, Kirkmann-Liff, *Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany: An Alternative Path to Universal Coverage, in Caring for the Uninsured and Underinsured*, American Medical Association, 1991.
[5] Health Security Act, Section 1001 (b)
[6] Id., Section 1601
[7] Id., Subtitle C, *et. seq.*
[8] Richard Epstein, "Unmanageable Care," *Reason*, May 1993.
[9] Alain Enthoven, *Managed Competition in Health Care Financing and Delivery: History, Theory and Practice*, Robert Woods Johnson Foundation, 1993.
[10] Etheridge, Supra, Note 1.
[11] According to the Institute for Research on the Economics of Taxation (IRET), a mandate for employers to provide health insurance "would result in unemployment that would fall most heavily on lower income workers whose salary approaches the minimum wage." Cordato, *Universal Health Care at Any Cost*, Institute for Research on the Economics of Taxation, February 20, 1989.

The National Federation of Independent Business (NFIB), which represents more than 500,000 small businesses in all 50 states, surveyed its members and found that 23% would be forced to lay-off employees if an employer mandate imposed an additional cost of only $100 per employee per month. Nearly 22% indicated that they could be forced out of business altogether.[12]

Indeed, a March 1992 study by the Joint Economic Committee of Congress estimated that more than 1.2 million jobs would be lost within one year of enactment of federally mandated health insurance. Other economists have placed the estimate of jobs lost at between 630,000 and 3.5 million.[13]

There is a particular unfairness to such a mandate. While most individuals without health insurance are the working poor, studies show that 25% of the uninsured have incomes greater than 300% of the poverty level.[14] These are frequently young, healthy individuals who have chosen not to purchase health insurance, preferring to spend their discretionary income elsewhere. Under an employer mandate, low-skilled, poor people would lose their jobs to provide these relatively affluent individuals with government-funded health insurance.

Second, the proposal creates a huge new bureaucracy, the National Health Board, as well as mini-bureaucracies at the state level in the Health Alliances. While the proposal fails to offer any real estimate of the cost of these agencies, those costs can be assumed to be substantial.

Third, the call for a guaranteed National Benefits Package simply moves the problems of mandated insurance benefits from the states to the federal level. Inclusion in the mandated benefits package is much more likely to be based on the relative lobbying strength of various provider groups than on a rational view of medical necessity. Already the scramble is beginning with women's groups demanding coverage for abortion and more frequent mammograms,[15] disputes over the extent of mental health coverage, etc.[16] Whatever benefits are mandated will increase the cost of insurance. And, consumers will be deprived of the ability to make individual choices on the type of benefits they wish to purchase.

Fourth, requirements for guaranteed issue and community rating will increase the cost of insurance. Insurance is a business of risk allocation, in which the insurer receives payment in exchange for agreeing to cover the expense of certain risks. The cost and scope of coverage is determined by morbidity/mortality statistical analysis.[17] To the degree that insurers are prevented from basing their contracts on such actuarial values, other policyholders will be forced to absorb the additional costs.

The whole theory underlying community rating is essentially a flawed one — that healthy people and sick people should pay the same for insurance. Since sick people inevitably require greater benefits, the cost of insuring them must be subsidized by healthy people. Thus, in order to provide coverage for a person with AIDS, a person without AIDS must pay a higher premium. Moreover, the additional costs are highly regressive in nature, forcing the highest marginal costs on those least able to afford the increase. For example, if community rating causes the premiums for a family policy to increase by $1,000, that's a 10% surcharge for a family earning only $10,000 per year, but only a 1% surcharge for a family earning $100,000.[18] The subsidization is also regressive because those low-risk persons, who will see their premiums increase, tend to be young with lower incomes, while high-risk persons, who will be subsidized, tend to be older and have higher incomes.

Finally, we should recognize that community rating relieves individuals of the responsibility for unhealthy lifestyles. There is no question that individuals who smoke, drink, use drugs, practice unsafe sex, have poor diets and fail to exercise have far higher health costs than individuals with healthy lifestyles. In fact, the top ten causes of death in the United States are all lifestyle related.[19] But, by spreading the cost over the entire population, community rating and guaranteed issue "socialize" the costs in the truest sense of the word.

Perhaps nothing better illustrates the failures of community rating than recent events in New York. On April 1, 1993, New York began to enforce the nation's most stringent community rating and guaranteed issue requirements.[20] The result has been astronomical increases in insurance premiums, in some cases doubling and tripling rates. The average premium for a 30 year-old male will increase from $1,200 per year to $3,240, a 170 percent hike. A family policy for a 30 year-old will jump 91 percent, from $4,020 to $7,680, well beyond the reach of most lower- and middle-income families. Of course some will benefit under New York's plan. The elderly will see a reduction in their premiums of nearly 50 percent.[21]

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[12] Statement of Charles P. Hall, Jr., Ph.D., Temple University, on behalf of the Federation of Independent Business before U.S. House Ways and Means Committee, Subcommittee on Health, May 2, 1991.

[13] *Health Care's Road to Recovery: Address the Cost and Access Problems Now, Partnership on Health Care and Employment*, September 23, 1991.

[14] Lewin/ICF analysis of Current Population survey data, March 1988.

[15] Chen, *Advocates for Women See Problems In Health Reform*, Los Angeles Times, October 6, 1993

[16] Pear, *Clinton Health Team's Radical Idea: A Standard Benefit Package for All*, New York Times, April 13, 1993.

[17] J. Scherzer, *How Insurance Rates Are Calculated In AIDS and the Law* (Washington: American Civil Liberties Union, 1989).

[18] Craig, *Guaranteed Issue: Guaranteed to Make the Problems In the Small Group Market Worse*, Council for Affordable Health Insurance, September 1992.

[19] Id.

[20] See, Tanner, *Laboratory Failure: States No Model for Health Care Reform*, Cato Institute, August 1993.

[21] Levin, *Health Cost Zooming Up*, New York Daily News, March 10, 1993., citing figures from the New York State Insurance Department.

Fifth, the Clinton plan will severely limit consumer choice — choice of insurer, choice of benefits, and choice of physician. Numerous studies have shown that Americans do not like restrictive managed care plans that limit their choice of physicians.[22] Because the cap on premiums, community rating and other restrictions in the President's plan generally prevents insurers from competing on the basis of their ability to price and manage risk, most traditional insurers would be driven out of the market. The criteria established for certified health Plans essentially limits the market to "the Blues" — Blue Cross and Blue Shield — and a handful of large HMO's.[23] Thus, the support for the Clinton health plan by these insurers.

The Clinton plan also holds the potential of severely disrupting the traditional doctor–patient relationship. Managed competition changes insurers from "financial intermediaries with expertise in underwriting risks" to "health care delivery systems... organizing, managing and purchasing medical care."[24] In short, advocates of managed competition believe physicians should be responsible to insurers, rather than the patient. This means that patient choice of physician should be limited to give the insurer increased bargaining power with the doctor. It also means increasing insurer control over the physicians choice of treatment, so that insurers can "apply quality assurance or review of appropriateness."[25]

As Swiss medical philosopher Ernest Truffer has noted, the increasing interjection of third–parties between doctor and patient "amounts to a rejection of the *medical* ethic — which is to care for a patient according to the latter's specific (medical) requirements — in favor of a *veterinary* ethic, which consists in caring for the sick animal not in accordance with its specific medical needs, but according to the requirements of its master and owner, the person responsible for meeting any costs incurred."[26] (Emphasis in original.)

Finally, the proposal is vague about how it will control overall health costs. Advocates of managed competition have a tremendous faith in the ability of "managed care" to control health care costs, which is not surprising considering the close ties between them and the managed care industry.[27] However, a recent survey indicated that half of employers who switched from non–managed care plans to HMO's said their HMO rates were as high or higher than their previous rates.[28] Likewise, a Congressional Budget Office Report found that shifting Medicare patients to HMO's "had little or no effect on hospital use and costs."[29] In addition, a recent Rand corporation study indicates that managed care providers were as likely as fee–for–service providers to perform unnecessary procedures.[30]

It is very difficult to judge whether managed competition can deliver its promised cost savings because no such system currently exists anywhere in the world. However, it is at least worth noting that one of the models for managed competition cited by the Jackson Hole Group is the Federal Employee Health Benefits Program (FEHBP).[31] However, despite recent enthusiasm for FEHBP by some conservative groups such as the Heritage Foundation,[32] FEHBP costs have actually risen faster than employer–provided health benefits in general.[33]

The Libertarian Alternative

The Libertarian Party believes that the only health care reforms which are likely to have a significant impact on America's health care problems are those that draw on the strength of the free market. The Libertarian Party has developed a comprehensive proposal for health care reform that will reduce health care costs, while extending access to care. It is a program based on the idea that health care is a personal responsibility, not a government one.

1. Medical Savings Accounts.

Under federal tax law, money spent by an employer on a worker's health insurance is not counted as taxable income to the worker. Thus, even though that money is part of the worker's total compensation, the worker avoids paying any income or payroll taxes on it.

This tax treatment gives American workers and their families very generous tax relief on their medical expenses, but only on

[22] Kaiser, *More Than Just Managed Competition*, Atlanta Business Chronicle, April 9, 1993.
[23] Miller, *How to Think About Health Care Reform: Disasters of Price–Fixing and Cost–Shifting Can't be Cured by More of the Same*, Independence Institute, February 5, 1993.
[24] Kent Masterson Brown, *Foundations Targeted*, AAPS News, May 1993 (quoting Alain Enthoven).
[25] Id.
[26] Cited in Goodman, *Canadian Health Insurance: Political Promises, Public Perceptions, Practical Problems*, Georgia Public Policy Foundation, February 1992).
[27] For example, Alain Enthoven is a paid consultant to Kaiser Permanente, and Paul Ellwood drafted the 1973 legislation that legally established HMO's. *What Drives the Managed Competition Movement?* "Intellectual Ammunition, March 1993.
[28] Health Care Benefits Survey 1991, Report 2, Managed Care Plans, A. Foster Higgins Company, 1992.
[29] *The Effects of Managed Care on Use and Costs of Health Services*, CBO Staff Memorandum, (Washington: Congressional Budget Office, June 1992).
[30] Study: *Managed Care No Cost Cure–All*, Atlanta Constitution, May 12, 1993.
[31] Alain Enthoven, *Health Plan, The Only Practical Solution to the Soaring Cost of Medical Care*, 1980.
[32] Moffit, *Consumer Choice in Health: Learning from the Federal Employee Health Benefits Program*, February 6, 1992.
[33] Goodman, *Managed Competition — Too Little Competition*, Wall Street Journal, January 7, 1993.

two conditions. First, they must obtain their medical care through health insurance. And second, they must obtain their health insurance through their employer.

In many cases, however, it would be more desirable or cost effective to purchase low-cost or routine medical care directly out-of-pocket rather than filing an insurance claim, or to buy a different health insurance plan than the one offered by the employer. Workers are heavily penalized for doing this because they receive no tax relief for doing so.

To make matters worse, a worker who has employer-sponsored health insurance, who is cost-conscious, and seeks out providers who offer good quality at good prices, is not rewarded, since he or she cannot pocket any savings. Moreover, physicians who dispense more services, regardless of their benefit, or charge higher prices, are rewarded with more income.

One method of solving this problem is the adoption of Medical Savings Accounts (MSA),[34] under which an individual should be exempted from taxes on money deposited in a medical savings account in the same way that he currently pays no taxes on deposits to an IRA. Money could be withdrawn from an MSA without penalty to pay medical expenses.[35] This would increase consumer responsibility, while increasing access and controlling costs. With such a program in place, employers could be expected to change the way they provide insurance. Rather than continuing to provide high-cost insurance benefits, with low deductibles and extensive benefits, employers could provide each employee with an annual allowance of perhaps $2,000, which the employee could deposit in the MSA. For medical expenses in excess of the $2,000, the employer would continue to provide health insurance, but such catastrophic coverage would be relatively inexpensive.

The individual would be responsible for paying his own health care expenses under $2,000, using funds from the account.[36] It should be noted that less than 12.5% of all insured individuals have annual claims in excess of $2,000.[37]

Unspent money in the account would accumulate and belong to the account holder. Prior to age 65, there would be a penalty applied to withdrawals for other than health care expenditures.

2. Establish Tax Equity.

A second consumer-based reform is changing those tax laws that discriminate against people that do not have employer-provided health insurance. The solution: All health care expenditures should be 100% tax deductible. In addition to expanding health care access, such tax changes would 1) establish a basic fairness in government policy — giving the same tax break to the waitress who has to buy her own health insurance that we are currently giving to the well paid executives of wealthy corporations, and 2) would hold down overall health care costs by increasing consumer involvement in the health care marketplace.

The difference in tax treatment creates a disparity that effectively doubles the cost of health insurance for those people who must purchase their own. For example, the family of a self-employed person, earning $35,000 per year, having to pay federal and state taxes with only a 25% deduction, and having to pay Social Security taxes, must earn $7,075 to pay for a $4,000 health insurance policy. A person working for a small business that offers no health insurance, would have to earn $8,214 to pay for that $4,000 policy.

The results of this inequity can be clearly seen. Those workers who must use after-tax dollars to purchase health insurance are 24 times more likely to be uninsured than those who are eligible for tax-free employer-provided coverage.[38]

Significantly, the poor and minorities, who are less likely to have employer-provided insurance, are the most likely to be left without access to health insurance.[39] Thus, the perverse impact of our tax policies is to subsidize the purchase of health insurance by the most affluent in society, while penalizing those less well off.[40]

While limiting access to health insurance, our tax policies also have an adverse impact on health care prices. By encouraging employer-provided coverage to the detriment of individually-purchased coverage and/or out-of-pocket payment, our tax policy increases the trend toward divorcing the health care consumer from health care payment.

As discussed previously, most health care consumers do not pay for their health care. On the average, for every dollar of health care services purchased, 76 cents is paid by someone other than the consumer who purchased it.[41] As a result, consumers have little incentive to question costs and every incentive to demand more services.

Establishing tax equity will encourage health care consumers to

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[34] John Goodman and Gerald Musgrave, *Patient Power: Solving America's Health Care Crisis*, (Washington: Cato Institute, 1992).

[35] Id.

[36] See e.g., Rooney, *Give Employees Medical IRA's and Watch Costs Fall*, Wall Street Journal, January 22, 1992.

[37] Based on claims experience in Chicago, one of the nation's highest cost areas. In more typical areas, about 9% of claims exceed $2,000. Based on claims distribution analysis by Tillinghast corporation.

[38] Foley, *Uninsured in the United States: The Nonelderly Population Without Health Insurance, An Analysis of the U.S., March 1990 Current Population Survey*, Employee Benefits Research Institute, April 1991.

[39] Id.

[40] Not only are high income workers more likely to have employer-provided health insurance, they also have higher marginal tax rates. Therefore, tax deductions are worth more to them.

[41] Goodman, *Plan Would Cut Health Costs, Put Patient in Control*, Atlanta Journal, April 10, 1992.

become more involved in the health care system. Individuals who purchase their own insurance are more likely to "shop around" for the best deal. And, individuals who purchase health care out-of-pocket are much more likely to make cost-conscious health care decisions.[42]

3. Deregulate the health care industry.

There should be a thorough examination of the extent to which government policies are responsible for rising health costs and the unavailability of health care services. We can help lower health care costs and expand health care access by taking immediate steps to deregulate the health care industry, including elimination of mandated benefits, repeal of the Certificate-of-Need program, and expansion of the scope of practice for non-physician health professionals.

For example, having decided that people are not smart enough to choose their own health insurance benefits, every state has laws that mandate that all health insurance contracts in their state provide for coverage of specific disabilities/diseases and the provision of specific health care services. These mandates add significantly to the cost of health insurance.[43]

Blue Cross and Blue Shield of Maryland estimates that mandated benefits account for 13.3 percent of all claims dollars.[44] And, in Massachusetts, Blue Cross and Blue Shield estimates that mandated benefits add nearly $55 per month to the cost of a policy.[45] Surveys of small businesses have repeatedly shown that the cost of health insurance is the number one reason why these businesses do not offer health benefits. By making insurance more expensive, mandated benefits are contributing directly to the number of uninsured.

In addition, a majority of states continue to maintain regulatory restrictions on health care services that act as a barrier to competition, such as Certificate-of-Need requirements. This is a regulation that says that if someone wants to build a new hospital, or buy a new piece of medical equipment, or offer a new type of medical service, they must first get permission from the government.

Certificate-of-Need is based on the bizarre economic theory that greater supply and increased competition will lead to higher prices. However, studies have repeatedly demonstrated that CON programs not only fail to contain costs, but may actually lead to increased costs, while limiting the availability of medical services, particularly in rural areas. The Trade Commission has concluded that, on a national basis, "Hospital costs would decline by $1.3 billion per year if states would deregulate their CON programs."[46]

We also need to rethink our medical licensing laws. Studies have repeatedly shown that qualified mid-level nonphysician practitioners can perform many medical services traditionally performed by physicians. Yet, the medical profession has consistently used licensure and other regulatory restrictions to limit competition. The result has almost inevitably been higher prices for consumers. For example, 37 states continue to outlaw the practice of lay midwifery. In most states, nurse practitioners cannot treat a patient without direct physician supervision. Chiropractors cannot order blood tests or CAT scans. Nurses, psychologists, pharmacists and other practitioners cannot prescribe even the most basic medications.[47]

Deregulating the health care industry will reduce the cost of health care overall, making health insurance more affordable and, therefore, easier to obtain.

4. Replace the FDA.

The Food and Drug Administration is one of the most dangerous and counter-productive of all federal government agencies. The mission of the FDA is obstensibly to protect the public from unsafe and ineffective medicines (and foods of course). However, in reality, the FDA has provided little protection, but has driven up health care costs and deprived millions of Americans of the health care treatment they need.

It now costs more than $231 million to bring a new drug to market, an increase of 327% since 1976. It also takes approximately 12 years to complete the process.[48] A substantial portion of that time and money is the result of the FDA approval process. Indeed, some studies indicate that the FDA doubles the cost of developing a new drug.[49] The cost, of course, is passed along in

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[42] There are numerous studies that show health care consumers do make cost-conscious decisions when given a financial incentive to do so. For example, the Rand Corporation conducted a study of 5,809 people, involving the change in health care decision-making based on the size of the consumer's co-payment. The study found that an individual with a 50% co-payment spent 25% less on health care than an individual with no co-payment. Manning, et. al, *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment*, American Economic Review, June 1987.

[43] John Goodman, Michael Tanner, and Duane Parde, *"Mandated Insurance Benefits: The Wrong Prescription,"* (Washington: American Legislative Exchange Council, January, 1991).

[44] *"Mandated Benefits Study,"* Blue Cross and Blue Shield of Maryland, (Baltimore, March 1988).

[45] *"Mandated Benefits Study,"* Blue Cross and Blue Shield of Massachusetts, (Boston, November 1988).

[46] D. Sherman, *"The Effect of Certificate-of-Need Laws on Hospital Costs: An Economic Policy Analysis,"* (Washington: Federal Trade Commission, January 1988).

[47] Michael Tanner, *"Returning the Market to Medicine,"* in *Market Liberalism: A Paradigm for the 21st Century*, (Washington: Cato Institute, 1993). See also Friedman, *Free to Choose*, 1980

[48] DiMasi, *Good Medicine: A Report on the Status of Pharmaceutical Research*, Tufts University, 1990.

[49] Kazman, *Deadly Overcaution: The FDA's Approval Process*, Journal of Regulation and Social Costs, September 1990.

the form of higher prices for consumers. In addition, the high cost of the approval process acts as a barrier to entry, benefiting large pharmaceutical companies, by preventing competition from smaller firms that have limited financial resources.

Even more tragic is the loss of human life that results from delays caused by the FDA approval process. For example, during the 10-year delay in allowing propanolol (the first widely used beta-blocker for treatment of angina and hypertension) to be marketed in the United states, approximately 100,000 people died because the drug was unavailable.[50] In addition, according to George Hitchings, winner of the 1988 Nobel Prize in Medicine, the FDA delay in approving the anti-bacterial drug Sepra cost more than 80,000 lives.[51]

Now the FDA is attempting to expand its reach, seeking to extend its authority to cover such items as vitamins and herbal remedies. The agency is also seeking broader subpoena, seizure and surveillance powers.

The FDA is clearly an unnecessary burden on the American health care system. There is no evidence that the agency offers Americans any real protection, but there is massive evidence that it is causing great harm. The agency should be abolished and replaced with voluntary certification by a private-sector organization, similar to the way Underwriters Laboratory certifies electrical appliances.

5. Privatize Medicare and Medicaid.

The current Medicare and Medicaid systems have clearly failed. Costs are skyrocketing. Medicare costs have increased to the point where the system is in serious jeopardy. Medicare Part A, which pays for hospital care and services, is projected to be unable to meet its financial commitments by the year 2005. It is estimated that to restore the fund's financial stability will require increasing the Medicare payroll tax from 2.9% to at least 6.5%. Medicare Part B, which pays for physician services, is hardly in better shape. General revenue contributions to Medicare Part B may increase 300% by the end of the century. And, premium contributions by the elderly may have to increase by a similar percentage.[52]

Medicaid is in much the same condition. The state share of the joint federal-state program is growing twice as fast as overall state spending. Some estimates indicate that state spending on Medicaid could increase a phenomenal 480% by the year 2000. The federal share of the program is growing even faster.[53]

At the same time, patients are receiving second rate care. Studies have shown that both Medicaid and Medicare patients have higher mortality rates than patients with private insurance.

Finally, providers are being shortchanged. Both Medicare and Medicaid reimburse providers at a rate well below the actual cost of procedures. As a result, fewer and fewer providers are willing to participate in the program. Those who do, pass along their costs to patients with private insurance, a practice known as cost-shifting.

The time is ripe for drastic reform. The federal government should begin to restructure the system to give Medicaid and Medicare recipients more flexibility to purchase private health insurance. Some experts suggest a voucher system would be a solid interim measure to bring Medicare and Medicaid recipients back into the private sector.[54] Other experts point to the potential for expanding the role of nonprofit charitable institutions in replacing government programs.[55]

Summary

The Libertarian Party believes that not only can free market solutions to health care reform lower costs, expand access to care, and protect individual choice, they are the *only* solutions that will solve our nation's health care crisis.

[50] Arthur D. Little, *Cost-Effectiveness of Pharmaceutical #7: Beta-Blocker Reduction of Mortality and Reinfarction Rate in Survivors of Myocardial Infarction: A Cost-Benefit Study*, 1984.
[51] Ruwart, *Healing Our World* (Kalamazoo, MI, 1991)
[52] 1988 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds, May 1, 1988, Appendix F.
[53] Families USA Foundation, *Rising Health Costs in America*, October 1990.
[54] *See e.g.*, Tanner, *Getting Off the Critical List: A Prescription for Health Care Reform in Georgia* (Atlanta: Georgia Public Policy Foundation, 1992)
[55] Bennett, *The Health Crisis: Where Are the Charities*, Alternatives in Philanthropy, November 1993.

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About the Libertarian Party

The Libertarian Party is America's third largest political party. Its platform advocates individual liberty, respect for the Bill of Rights, free enterprise, free trade, and no meddling overseas. In 1992, Libertarian candidates for state and federal office won more than 3.7 million votes. There are about 180 Libertarians currently in elected or appointed office around the USA.