

Drug Prohibition in the Light of Public Health Care

Private Health Insurance in Drug Use: A Free Market Solution to Drugs

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According to the prevailing opinion, drug use results in additional costs to public health care system because drug users impose significant negative externalities on the rest of society (see Miron and Zwiebel 1995, 183). One of the main goals of drug prohibition is to protect public health against drug use and reduce these social costs by discouraging drug consumption (see Miron and Zwiebel 1995, 175). This article will try to rebuild this widely accepted myth that negative externalities originate on the side of drug users, and introduce negative externalities in drug use as a consequence of government regulations.

As it will be shown, the government effort to protect public health against drug use via drug prohibition has to fail. The main reason of this failure is the existence of public health insurance, which replaces personal responsibility and liability for one's own health by government coercion and state regulation of health care. In states with public health insurance (mainly in Western welfare states), the government creates externalities in drug use because it forces people to pool their risk with drug users and bear their health care costs. On the contrary, drug users have no economic motivation to stop using drugs when others cover their health care. Therefore, public health insurance supports drug users in their activities and it forces ordinary people who would have nothing in common with drugs in the free market to subsidize drug use and become involuntary sponsors of drug users. From the economic point of view, it is an ineffective situation, when more people are motivated to use drugs than in case of private insurance. On the other side, health insurance companies are not allowed to solve this problem by risk diversification and charging different insurance premium rates among their clients according to their expected claim costs. Instead of it, government interventions replace private markets and create pressure for expansive government programs, the costs of which have to be paid by ordinary people. As a result of these government regulations, people who do not use drugs have to bear double external costs. Due to public

health insurance, they must share health care costs with drug users, and due to drug prohibition, they must contribute from their taxes to the futile fight against drug use. In this light, government regulations become the source of externalities in drug use.

After analyzing these government regulations, a free market solution to drug use will be introduced in this article. Drug prohibition cannot be an effective means for public health protection against drug use, as it will be described. Instead of drug prohibition, some other approaches have been offered as drug policy. These approaches include legalization (Friedman 1972, Barro 1997, Thornton 1991, Miron and Zwiebel 1995, Miron 2004,), taxation (Becker 2001), decriminalization (Rasmussen and Benson 1994), medicalization (Howitt 1990, Pearson 1991), or harm-reduction (Reuter 1991).¹ The solution presented in this article stems from the liberal approach represented, for example, by Mises ([1927] 1985, 52 – 55), Rothbard ([1973] 2006, 136 – 137), or Block (1996, 433 – 436) and it is built on three main factors: personal liberty and responsibility in drug use, and especially on the existence of private health insurance in the free market.

This article is divided in five parts. The first part analyzes the concept of public health itself and the consequences ensuing from the transformation of human health to a collective good. The second part focuses attention, within the public health care realm, on public health insurance and its relationship to drug use. The third and fourth parts are devoted to drug prohibition and its impact on public health. The third part examines this issue from a social perspective. Drug prohibition will be identified as a source of government externalities in this part. The fourth chapter will then show the impact of drug prohibition on the health conditions of drug users themselves. The last chapter will summarize the acquired knowledge and outline a possible free market solution for the elimination of externalities in drug use based on the above mentioned factors.

Human Health as a Public Good

Since the time of the English moral philosophers of the 18th century, the property was understood in a very broad meaning which included not only the protection of tangible goods and the ensuing possibility of division of labor and exchange, but also the protection of human life and freedom of each individual. Human health was considered as the property of each individual, as an inseparable part of self-ownership. John Locke expressed this idea in

¹ See Thornton (2007) for the comprehensive survey of different approaches to drug policy.

his Second Treatise of Government, when he wrote that “[t]hrough the earth, and all inferior creatures, be common to all men, yet every man has a *property* in his own *person*: this no body has any right to but himself” ([1690] 1980, 19, emphasis in original). Later on, Rothbard demonstrated that human rights (the right to self-ownership) have to be in fact only a particular type of property rights and by denying them, we would deny the institution of private ownership itself:

For not only are property rights also human rights, but in the most profound sense there *are* no rights but property rights. The *only* human rights, in short, are property rights. There are several senses in which this is true. In the first place, each individual, as a natural fact, is the owner of *himself*, the ruler of his own person. The “human” rights of the person that are defended in the purely free-market society are, in effect, each man’s *property right* in his own being, and from *this* property right stems his right to the material goods that he has produced. ([1970] 2006, 291, emphasis in original)

Freedom of every man is manifested by the fact that he owns, except his property, his own body and decides about its use, i.e. uses his body to pursue his own interest. This results from the merits of the case. If a man is the owner of a particular material good, then he has all property rights belonging to this good (he can dispose of it according to his will, he can use it for his own purpose, he can let it go to waste or freely decide that he will destroy it). If this is true about material goods, then exactly the same has to be valid unexceptionally also for self-ownership, for ownership of own body, otherwise the institution of private ownership itself would be denied. Therefore, a man as a free being has to fully decide about how to dispose of his own body. Every free man is the final arbitrator who decides whether he will use his body for work or, on the contrary, for idling, whether he will try to protect his body (e.g. he will eat healthy food, do sports regularly) or whether he will harm his body by unhealthy activities (he will smoke, drink alcohol or use other drugs). No matter how he decides, it is always in his competency. John Stuart Mill identified this fact in his famous essay On Liberty, when he wrote that “[o]ver himself, over his own body and mind, the individual is sovereign“ (qtd. in Boire 2002, 254). And as Boire sums up Mill’s thoughts, “[w]hat happens *inside* a person’s body or mind is that person’s private business, not the business of society and certainly not the business of the government...So long as a person’s decision and subsequent conduct did not threaten others with harm, Mill considered the person’s action to lie within a protected “region of human liberty”“ (2002, 254, emphasis in original).

Any free society has to be completely based on the principle of self-ownership, and every man has to be the only person who will eventually decide what will happen to his body; i.e., every man has to own his body, otherwise a conflict would inevitably arise – someone else than the owner might make decisions about his body. And that is the case of drug prohibition. The following research will demonstrate that drug prohibition completely denies the concept of self-ownership and property rights, and instead of the man himself the state and its clerks begin to make decision about his body. One of the main causes staying behind drug prohibition is denying the principle of self-ownership, ownership of the human body, and replacing it by public health care.

The necessary condition for providing public health care is the definition of human health as a public good. In Western welfare states, the protection of public health became one of the most important spheres of government interest during the 20th century. The concern for human health and the responsibility of each individual for its protection was gradually replaced by the general right to health care. The right to health care even became, in many countries, one of the highest legal standards (see WHO 1999). However, it is necessary to point out that the right to health, as a part of social rights, can never be in compliance with property rights, but on the contrary, that these two rights mutually exclude each other.

Property rights limit to every man a sector of his own individual freedom. As Hayek (1976, vol. 2) showed, the protection of private ownership is a necessary part of the natural order where everybody is equal in the sense of equality before the law (where no individuals or groups have special legal privileges and where each individual is subject to the same laws). As Hayek (1976, vol. 2) added, a violation of property rights (private ownership) leads to the extinguishment of equality and to the division of society into privileged groups. The redistribution of wealth and property among individual groups of citizens in order to achieve social rights (social equality) becomes a common part of the economic policies of all governments worldwide. A big victory for politicians and legislators was that they succeeded in changing the meaning of the word “equality” (as defined above) to “social equality”; the original idea of equality before the law was replaced by social equality especially during the 20th century (see Hayek 1976, vol. 2). This caused an unprecedented attack on private ownership as well as on individual freedom because social equality can only be achieved to the prejudice of private ownership. Mises wrote concisely in this context that “freedom is incompatible with equality of wealth and income” ([1949] 1996, 287).

The transformation of human health from a private to a public good can be seen as a consequence of enforcing these social rights in society during the 20th century. At the same

time, this change brought one of the biggest attacks on property rights as well as on the principle of self-ownership. A man is no longer a sovereign ruler of his own body but, on the contrary, government power to intervene in human behavior grows.

The definition of human health as a public good represents the first and necessary condition for the government to take control over its people. Under the pretext of taking care of human health state power over its citizens unobtrusively flourishes as well as the bureaucratic apparatus grows (see Szasz 2001, 491 – 492 for some statistics illustrating the explosive growth of public health care system in the United States after the end of World War II). By replacing the responsibility of each individual for his own health with state control over public health, a great deal of power is moved into the hands of the government. Politicians gain the position of public physicians. Nevertheless, while real physicians treat real illnesses of specific individuals (that is why they can determine an exact diagnosis and effective treatment methods), politicians treat public health of the whole society at once. Because of the impossibility of specifying public health as an economic good (human health is an integral part of self-ownership, the public has no body; therefore, from the medical point of view, it cannot be either healthy or ill), new methods of treatment arose. Political regulations, bans or other forms of intervention became methods of public health care and the treatment itself gained the character of coercion (see Szasz 2001). While real physicians try to treat people with diseases such as lung cancer or hepatic cirrhosis, the political physicians try to treat society as a whole by preventing people from using drugs or drinking alcohol. As Richards and Rathbun write, “[p]ublic health is not about making individuals healthy; it is about keeping society healthy by preventing individuals from doing things that endanger others” (qtd. in Szasz 2001, 486). That is why the protection of public health requires state coercion and enforcement, unlike the protection of human health, which is built on personal responsibility and liberty.

Generally, public health care system gives politicians the power to determine and order how people should live, what they can do, and what they have to avoid. In other words, it gives politicians the power to decide what all they will control. Of course, politicians constantly try to expand the area of their influence, as it will be shown below. Therefore, we can witness various government policies that have the objective to regulate human behavior in the name of public health. Gradually, these public health regulations lead to something what we might call “the nationalization of human health”. To a certain point, public health replaces public property ownership. Through public health care system, the politicians gain the power to decide on the ownership of the bodies of each of us. Szasz ([1963] 1989, 212) described

this sneaking process concisely as “the birth of the Therapeutic State”, which in Western welfare countries became a certain counterweight to the socialist states (the unsuccessful attempts for public property ownership is replaced by less visible, but not less dangerous, attempts for state ownership of the human body). While the socialist states were built on the illusion of the right of each citizen to ownership of public property, the Therapeutic state is connected with the idea of the general right to health.² In this context, public health can be, besides wars and crisis, identified as one of the main factors which, mainly in the 20th century, leads to the expansion of the government and its power over its citizens (see Higgs 1987). We find out how dangerous and uncontrollable growth of state power it is when we apply the idea of public health in all its consequences.

The protection of public health is one of the main reasons behind drug prohibition (for example, see WHO 1999, 90 – 96). If the government prohibits drug use, it will, according to the advocates of drug prohibition, lead to the improvement of public health. Nevertheless, at this point, we are getting to a very serious problem of the limits of state intervention in free human behavior. The majority of human activities brings potential health risks (e.g. driving a car can, in the case of an accident, lead to serious health damages or even death, as can playing sports lead to a great risk of injuries, not to mention the influence of an unhealthy diet or smoking cigarettes on human health). A principal question emerges: should the government, in all cases where there is a potential risk for human health, preventively prohibit these activities? Should it, for example, prohibit driving a car, participating in all sports (excluding maybe chess where no serious injuries are expected), or ban the selling of unhealthy food in order to prevent all serious health risks in society?

Certainly nobody thinks that the government should prohibit all sports activities because there is a lot of serious sports injuries, or that it should prohibit automobile transportation because thousands of people die yearly on roads as a consequence of accidents. Nevertheless, if we apply the logic of this government argument about the necessity of public health protection against health risks consistently, we cannot omit any of these activities. Using drugs as well as eating unhealthy food, smoking tobacco, driving a car, or participating

²Indeed, there is no right to health. Unfortunately, most of people do not recognize it until they are sick and need health care. As Goodman writes, “[i]n fact, no country with national health insurance has established a right to health care” (2005, 2). For example, according to UK Department of Health (qtd. in Goodman 1995, 3), in Britain, with a population of almost 60 million, more than 1 million are waiting to be admitted to hospitals at any one time. In Canada, with a population of more than 31 million, the independent Fraser Institute (qtd. in Goodman 1995, 3) found that more than 876 thousands are waiting for treatment of all types. In fact, many people have to wait in pain to be treated because there is no market principle in public health care system which would determine who really needs to get health care.

in risky sports represents a danger to human health. Once the government starts the process of health regulations in the name of public health protection, then nothing can stop it from prohibiting all these other potential dangers. Many economists have already warned about this situation. Mises wrote in a very exemplary way that everyone who defends state regulations in one field of human behavior has to defend complete totalitarian dictation in all human activities:

nearly everywhere some restrictions are imposed on the sale of opium, cocaine, and similar narcotics... Why should not what is valid for these poisons be valid also for nicotine, caffeine, and the like? Why should not the state generally prescribe which foods may be indulged in and which must be avoided because they are injurious? In sports too, many people are prone to carry their indulgence further than their strength will allow. Why should not the state interfere here as well? Few men know to be temperate in their sexual life, and it seems especially difficult for aging persons to understand that they should cease entirely to indulge in such pleasures or, at least, do so in moderation. Should not the state intervene here too?...We see that as soon as we surrender the principle that the state should not interfere in any questions touching on the individual's mode of life, we end by regulating and restricting the latter down to the smallest detail. The personal freedom of the individual is abrogated. He becomes a slave of the community, bound to obey the dictates of the majority. ([1927] 1985, 52 – 54)

Rothbard wrote in this context about smoking:

Every man has the right to choose. Propagandize against cigarettes as much as you want, but leave the individual free to run his own life. Otherwise, we may as well outlaw all sorts of possible carcinogenic agents—including tight shoes, improperly fitting false teeth, excessive exposure to the sun, as well as excessive intake of ice cream, eggs, and butter which might lead to heart disease. And, if such prohibitions prove unenforceable, again the logic is to place people in cages so that they will receive the proper amount of sun, the correct diet, properly fitting shoes, and so on. ([1973] 2006, 137)

This part can be closed by Szasz, who unveiled the factual meaning of the state fight for public health. He writes that “[t]he imagery in [the United States] is that the most important value is health. And in the name of health it is OK to lock up people, to beat people, to deprive them of their constitutional rights, and even to kill them” (1992, 162).

Public Health Insurance and Drug Use

Public health replaces personal responsibility and liability for one’s own health by government coercion and state regulation of health care, as it was shown in the previous chapter. The following chapters will focus on the concrete impacts of these health regulations in the market. It will focus mainly on drug prohibition, which represents one of the means for the protection of public health, specifically against the malignancy of drug use. It is necessary to start with the description of public health insurance, which can be considered as the main cause of the counter-productivity of drug prohibition in its effort to protect public health.

Generally, insurance originated as a means for the elimination of uncertainty and risk (Knight 1971). The main purpose of insurance was to “protect the insured from an unanticipated economic loss so large as to jeopardize his economic well-being” (Szasz 2003, 30 - 31). In the free market, insurance is characterized by three basic elements. Firstly, insurance represents a voluntary contract between the supply (the insurer) and the demand (the insured) side of the exchange on which both sides agree. It is the transfer of risk from one contracting party to another for an agreed payment. Secondly, in the free market, insurance can be offered only against events, the results of which cannot be, in any way, systematically influenced by the insured. Risks whose likelihood an individual can systematically influence represent uninsurable risks in the free market.³ As Hoppe explains, “it is not possible to insure oneself against every risk of life. I cannot insure myself against committing suicide, for instance, or against burning down my own house, or becoming unemployed, or not feeling like getting out of bed in the morning, or not suffering entrepreneurial losses, because in each case I have full or partial control over the likelihood of the respective outcome. Risks such as these must be assumed individually. No one except myself can possibly deal with them” (2002, 6). Thirdly, insurance premium rates are determined by predicted risks and expected claim costs. Therefore, insurance companies charge various premium rates to various groups

³ On the fundamental distinction between insurable and uninsurable risks, see Knight (1971) or Mises ([1949] 1996, 105 – 118).

of policyholders, depending on their expected claim costs. Policyholders with relatively high expected claim costs pay relatively high premiums (for example, if someone wants to insure a house against natural disasters, he will pay a higher insurance premium in case his house is in a flood zone than when the house is in a relatively safe area where no flooding or other natural disaster is a threat). This helps the insurance companies to overcome the problem of asymmetric information to a great extent.⁴

When we summarize the above mentioned facts, we will get to the necessary characteristics of insurance in the free market. These are the voluntaries, the accidental occurrence of the events against which is one insured, and the relation between the insurance premium rate and the expected claim costs. If one of these elements is not met, we cannot talk about insurance in its “pure” form.

If we now take a closer look at public health insurance, which was established for the purpose of financing public health care service, and we confront it with the above mentioned characteristics, then we find out that it does not meet the criteria of insurance in the free market. Public health insurance replaces a voluntary contract between the insurer and the insured by the obligatory transfers to public health insurance funds. The insurance premium rate is not in any way related to the expected claim costs of the individuals but it is calculated as a fixed rate based on one’s income. Public health insurance has, therefore, no longer anything in common with insurance in its true meaning, but it is a compulsory income tax payment determined to fund public health care system. Public health makes from health insurance a tool of wealth redistribution in society and removes economic calculation from health care. As Hoppe writes, “[a]ll welfare states impose highly restrictive regulations on the health insurance industry. As a result, health insurance agencies have increasingly become

⁴ This fact contradicts to a great extent the theory of asymmetric information. According to Rothschild and Stiglitz (1976), policyholders know more about their risk of loss (for example, a drug user knows more about his dependence on drugs than the insurance company). Nevertheless, in the competitive insurance market, “private insurers seek to group buyers into classes with different expected claim costs [to reduce asymmetric information]. Risk classification in competitive insurance markets reflects low-cost information that insurers can use to predict differences in future claim costs among buyers. The more accurate the classification, the less asymmetric information“ (see Harrington 2000, 41). Insurance companies can use statistical methods (the law of large numbers, the probabilistic model etc.) for effective risk classification. Moreover, insurance companies can use a dynamic adjustment of “fair” insurance premiums according to the real claim costs of policyholders, so they can offer discounts on insurance premiums for lower than predicted claim costs and, on the contrary, extra charges for higher than expected claim costs. Regarding the past claim costs, insurance companies can sometimes decide not to extend the insurance contract with high risk customers. For these reasons, asymmetric information is suppressed to a great extent. In our case, insurance companies in the competitive insurance market can find out very well the health conditions of their clients (for example, whether they use drugs or not) and can effectively diversify the risk and set the accurate insurance premium.

machines of income and wealth redistribution, rather than of insurance” (1997, 473). Health insurance companies are not allowed, thanks to the general right to health, to consider risks and expected claim costs of their clients, charge them different insurance premiums, or refuse uninsurable risks. As Hoppe continues, “[b]ecause of legal restrictions on health insurers’ right of refusal – to exclude any individual risk as uninsurable and discriminate freely between different group risks – the health insurance industry in Western welfare states is only partly concerned with insurance” (1997, 474). Insurance companies, as a result of government health insurance regulation, have to cover a multitude of uninsurable risks, protect irresponsible people against the consequences of their behavior, and pay the medical expenses for their treatment. Szasz points out in this context a paradoxical difference between private and public insurance. “For example, a person cannot buy a policy to protect himself from a loss caused by his own actions, such as burning down his own home. But so-called health insurance protects the individual from the medical consequences of his own actions, for example, injuring himself by smashing his car while drunk” (2003, 30 - 31). Health insurance is, therefore, not in any way linked to the real health risks of the individuals and due to the egalitarian approach to all insured people and the collective method of financing, externalities can occur in public health care.

People who lead a healthy lifestyle have to, thanks to public health insurance, pool their risks with people who smoke cigarettes, use drugs, consume alcohol excessively, or overeat unhealthy foods. On the contrary, people who lead unhealthy lives have no economic incentives to change their lifestyles because they do not have to bear the increasing costs of their health care. The marginal health care costs of high-risk individuals are generally close to zero. The result is that irresponsible and high-risk individuals (in terms of insurance) can live at the expense of those with low insurance risks. Their health care costs are, in fact, spilled out into the whole society. Public health care system, therefore, creates externalities in society and supports risky behavior, such as drug use. Mercer proves this situation when she writes that, “[i]t is legally impermissible to exclude or refuse to insure certain risky populations...If insurers cannot transfer to the addict the full costs of the risk he poses, they must make those of us who choose to watch our diets, exercise, and refrain from smoking or drug taking the repository for these costs. Legislative interference ensures we subsidize the lifestyle of the smoker, compulsive eater, drinker, and addict” (2001).

Collective financing of health care, paradoxically, motivates drug users to continue in their behavior because such persons do not have to bear the additional costs of their treatment and thus have no economic incentives which would lead them to quit using drugs. The moral

hazard shows here very clearly. The demand for self-protection of drug users declines very rapidly when public health insurance decreases the costs related to this risk behavior to a minimum (see Ehrlich and Becker 1972, 641 – 643). In other words, if the health insurance premium rate is set up by a fixed rate regardless of the risks and expected claim costs of insured people, then drug users have no incentives to prevent health problems. Moreover, insurance companies themselves have less incentive to reduce health risks of their clients in the “free” or subsidized health care system (see Harrington 2000, 44). In public health care system, all people represent the same risk group, public health insurance companies have to charge them the same insurance premiums, and the moral hazard arises because “the consumers who pays only part or none of the marginal cost of services will knowingly take unhealthful actions and eschew healthful ones” (Shmanske 1996, 195). A compulsorily insured person behaves much less responsibly than if he had to pay an insurance premium consistent with his real health risk and behavior. Therefore, there is a missing economic motivation to eliminate drug use in public health care system. Drug users do not consider the costs which are related to their unhealthy lifestyles and their consequent treatment. Their behavior does not reflect the real costs. They systematically overestimate present benefits of drug use and their expected lifetime utility is more positive than it would be in case of health insurance in the free market (see Becker and Murphy 1988). Shmanske writes in this context that “smokers who are nearly indifferent about whether they should continue to smoke or quit will be more likely to continue smoking if they expect the costs of future smoking-related illnesses to be paid wholly or partly by a third party” (1996, 195).

Thanks to public health insurance, insurance companies have to cover countless numbers of uninsurable risks and cannot charge different insurance premium rates to different groups of citizens according to their risk and expected claim costs. As Hoppe points out, “[t]he industry thus runs a system of income and wealth redistribution – benefiting irresponsible actors and high-risk groups at the expense of responsible individuals and low-risk groups” (1997, 474). The principle of solidarity and equality, which in public health care system replaced personal responsibility and freedom, thus leads people to involuntary solidarity with drug users, alcoholics, smokers, overeaters and all other individuals who do not cherish their health. Szasz writes about this paradoxical situation: “[i]f some people do not value their own health, then it is a folly twice over for the taxpayer to pay for their health insurance” (2001, 495).

In this way, the government, via public health care system, supports drug users in their behavior. But that is the total opposite of what the government really want to do. Therefore, a

new regulation has to be implemented. One government regulation (public health regulation) creates a need for another regulation (drug prohibition).

Drug Prohibition as Public Health Regulation: Who Profits?

Public health insurance causes that drug users do not bear the increasing costs of their health care, which leads to the above described moral hazard resulting in excessive drug consumption. From the economic point of view, it is an ineffective situation, when more people are motivated to use drugs than in case of private insurance in the free market. On the other side, insurance companies are not allowed to solve this problem by risk diversification and charging different insurance premium rates among their clients. Instead of it, government interventions replace private markets and, as it will be described, “create pressure for expansive government programs” (Harrington 2000, 46). And as Harrington adds, “[t]he predictable result is less economic efficiency and more government spending” (2000, 46).

Even though we can find the historical roots of drug prohibition in many other areas than in the attempt to protect public health,⁵ it is undeniable that the protection of public health is one of the main arguments used by governments to defend drug prohibition (for example, see Thornton 1991, 72). Therefore, drug prohibition can be considered as a type of government health regulations.

Of course, drug prohibition is not the only form of government health regulations because people do not harm their health only by using drugs, but by many other activities, such as smoking cigarettes, excessive alcohol drinking, overeating unhealthy food, driving a car dangerously etc. Therefore, it is not a surprise that politicians try to regulate all these areas of human behavior in the name of public health protection. In reality, we can witness an increasing number of regulations which are justified exactly by the need to protect public health. These regulations touch all areas of human activities which increase the demand for public health care and where, due to public health insurance, exists a distortion between private and public health care costs. As it was written, the range of these health regulations keeps expanding. For example, in the United States, these regulations originally dealt mainly with the control over drugs and a short experiment with alcohol prohibition. Since the second

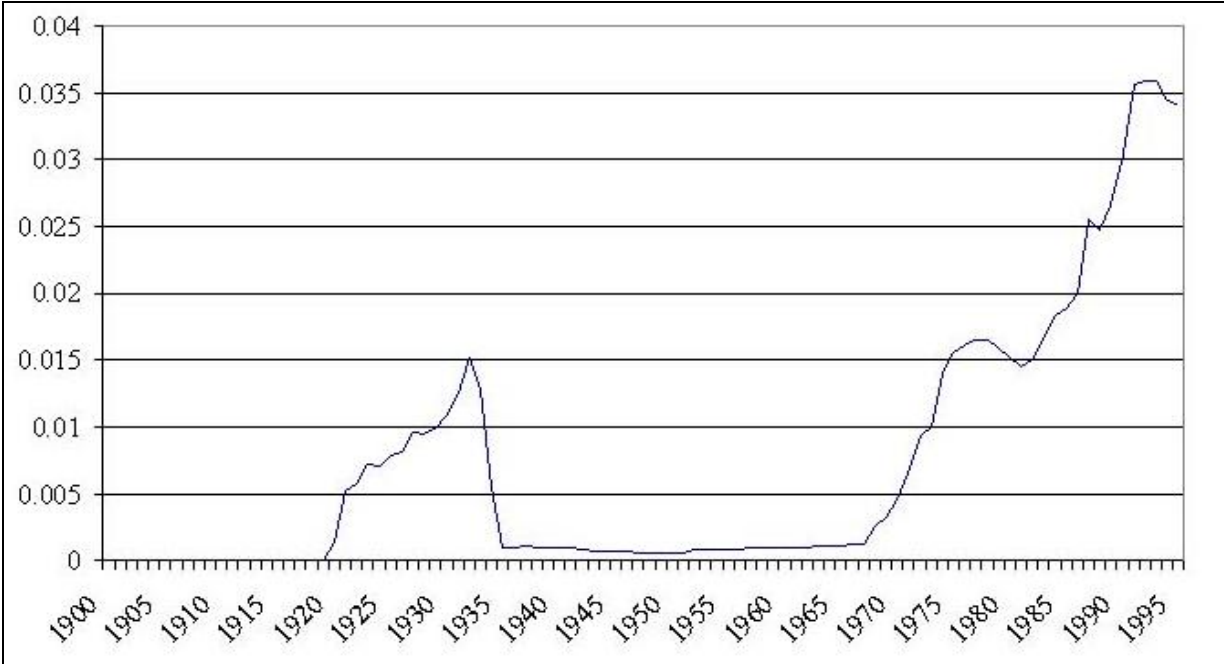
⁵ The historical roots of drug prohibition can be traced back to the beginning of the 20th century in the United States, where the newly implemented anti-drug policy served three main functions: to gain the economic control over the opium business in the markets of the Far East, to afflict the U. S. immigrants (especially Asians) and their habits, and to regulate and subsequently monopolize the drug business only for medical profession (see Cohen 1990, 8-14 or Musto 1973 for the origins of drug prohibition).

half of the 20th century, the government has undertaken all sorts of policies in the name of public health that are aimed at regulating personal behavior. As Balko shows, “[i]t began in the 1970s and 1980s with anti-smoking initiatives and today includes a wide range of programs, including efforts aimed at reducing alcohol consumption, encouraging seatbelt and motorcycle helmet use, regulating diet and lifestyle in the name of curbing obesity, federalizing local issues like speed limit and the minimum drinking age, and generally using the power of the state to regulate away lifestyle risk” (2006, 9). All of these regulations then impose other external costs on society.

Drug prohibition is one of the best examples of these government externalities. At first sight, drug prohibition should protect public health against the malignancy of drug use and thus limit public health care costs; nevertheless, it is necessary to point out here two main contradictory factors, which show the opposite direction in the origin of drug externalities. Firstly, as it was described in the previous chapter, it is the system of public health care with public health insurance which makes these externalities possible. There would be no external health care costs of drug users in the free market with private health insurance companies. Secondly, the external health care costs of drug users represent, in fact, only a fraction of the costs which people currently have to bear due to drug prohibition. In this context, there was published a RAND study in the United States, which estimates that an additional \$34 million expenditure on treatment would reduce U.S. cocaine consumption by 1 percent, while a similar reduction would be gained by a \$246 million expenditure on domestic law enforcement (Rydell and Everingham 1994). Therefore, it is estimated that for every dollar invested in the treatment of drug abuse, seven dollars in social costs are saved (Basham 2001, 6). Moreover, according to this study, additional domestic law enforcement efforts cost 15 times as much as treatment to achieve the same reduction in social costs (Rydell and Everingham 1994). Benson and Rasmussen write about it that “[t]reatment is relatively more effective because it cuts consumption directly, while law enforcement works by raising the price of drug offenses” (1996). Drug prohibition represents, paradoxically, the most expensive and the least effective method of protecting public health against drug use (Basham 2001).

If we take a closer look at the development of these costs in the United States, the world leader in enforcing drug laws, we will see the real picture of this effort to protect public health against drug use through drug prohibition. Figure 1 plots real per capita expenditures for enforcement of alcohol and drug prohibition in the 20th century, when these expenditures copy increasing prohibition attempts (vertical axis is measured in 1992 dollars).

Figure 1: Real per Capita Expenditures for Enforcement of Alcohol and Drug Prohibition in the United States



Source: Miron (2001)

Mainly the second half of the 20th century in the United States was related to a gigantic growth of resources devoted to drug prohibition. The best case of these growing government expenditures can be demonstrated on the main U.S. organization established to deal with enforcing drug laws, the Drug Enforcement Administration (DEA). Table 1 shows a huge increase in the DEA budget and staff.

Table 1: DEA Staffing & Budget (FY 1972 – 2005)

YEAR	Total Employees	Special Agents	Support Staff	Budget (\$ in Millions)
1972	2,775	1,470	1,305	65.2
1973	2,898	1,470	1,428	74.9
1974	4,075	2,231	1,844	116.2
1975	4,286	2,135	2,151	140.9
1976	4,337	2,141	2,196	161.1
1977	4,439	2,141	2,298	172.8
1978	4,440	2,054	2,386	192.3
1979	4,288	1,984	2,304	200.4
1980	4,149	1,941	2,208	206.7
1981	4,167	1,964	2,203	219.5
1982	4,013	1,896	2,117	244.1
1983	4,013	1,896	2,117	283.9
1984	4,093	1,963	2,130	326.6
1985	4,936	2,234	2,702	362.4
1986	4,925	2,440	2,485	393.5
1987	5,710	2,879	2,831	773.6
1988	5,740	2,899	2,841	522.9
1989	5,926	2,969	2,957	597.9
1990	6,274	3,191	3,083	653.5
1991	7,096	3,615	3,481	875.0
1992	7,264	3,696	3,568	910.0
1993	7,266	3,518	3,748	921.0
1994	7,049	3,611	3,438	970.0
1995	7,389	3,889	3,500	1,001.0
1996	7,369	3,708	3,661	1,050.0
1997	7,872	3,969	3,903	1,238.0
1998	8,452	4,214	4,238	1,384.0
1999	9,046	4,527	4,519	1,477.0
2000	9,141	4,566	4,575	1,586.6
2001	9,209	4,601	4,608	1,697.4
2002	9,388	4,625	4,763	1,799.5
2003	9,725	4,841	4,884	1,891.9
2004	10,564	5,194	5,370	2,040
2005**	10,894	5,296	5,598	2,141
*Enacted amounts may include rescissions if applicable. **FY 2005 Enacted Level				

Source: DEA 2009

Under the presidency of Richard Nixon, the DEA operated with a budget of \$65.2 million. Ten years later, the Reagan administration gave the DEA a budget of \$244.1 million. During the Clinton administration, this sum for the first time exceeded \$1 000 million and just nine years later, in 2004, under the presidency of G.W. Bush, the budget exceeded \$2 000 million. During the 30 year period, between 1972 and 2002, the DEA budget grew by an unbelievable 2 760% (without the inflation adjustment). In addition, the number of employees grew four times.

We can see the same trend in growing government expenditures on the federal level, where the budget devoted to the war on drugs doubled for the past 15 years (see Table 2).

Table 2: Historical Drug Control Funding (Budget Authority in Millions)

Year	1995	1996	1997	1998	1999	2000	2001	2002
Totals	7,045.6	6,808.2	8,090.6	8,179.0	9,760.1	10,703.0	10,401.4	10,781.4
Year	2003	2004	2005	2006	2007	2008	2009 Enacted	2010 Requested
Totals	11,220.1	12,005.6	12,784.2	13,144.1	13,844.1	13,276.3	14,844.8	15,069.1

Source: National Drug Control Strategy: FY 2004 Budget Summary (2003, 9), National Drug Control Strategy: FY 2010 Budget Summary (2009, 15)

As was illustrated, there was an enormous growth in government expenditure devoted to drug prohibition in the United States during the 20th century. One of the main purposes of these expenditures was, through the prohibition of drugs, to decrease the numbers of drug users and consequently to protect public health against drug use. Nevertheless, if we compare these expenditures to the development of drug users in the United States, we can hardly see any visible effect of this government spending. The accessibility of drugs has not decreased during the prohibition in the United States, but on the contrary, it has grown unbelievably in size compared to the pre-prohibition time. Basham writes about this government effort to regulate drug use:

The record of drug prohibition is a record of failure. The evidence of failure is all around us. Despite the vice squads, courts, prisons, and propaganda that form the “War on Drugs,” illegal drugs are everywhere, available to just about anyone who wants them. Today, the levels of illegal drug production and illegal drug profits are at an all-time high. Despite the greatest anti-drug enforcement effort in history, the drug problem is worse than ever. The

world-wide trade in illicit drugs is currently estimated at \$600 billion. That figure constitutes eight percent of all international trade, sufficient to line the pockets of an ever-expanding global criminal class. (2001, 3)

For example, Ostrowski compares cocaine use before the prohibition era (before the Harrison Act came into effect in 1914) and after seventy years of intensive law enforcement efforts to reduce drug use:

Perhaps the most telling indicator of the ineffectiveness of U.S. drug laws is their failure to reduce the overall use of illegal drugs. On a per capita basis, the use of narcotics was no more prevalent before prohibition than it is today, and the use of cocaine is more widespread today than when it was legally available. In 1915, the year the first national control laws became effective, there were about 200,000 regular narcotics users and only 20,000 regular cocaine users. Today, there are...two million regular cocaine users. Thus, with a population more than twice what it was in 1915 ... cocaine use has increased by more than 4,000 percent. (1989)

Government agencies themselves admit this situation. According to the DEA, in 1960, before the declaration of two Wars on Drugs (the first War on Drugs between 1965 and 1970 and the second War on Drugs between 1984 and 1989), “only four million Americans had ever tried drugs. Currently, that number has risen to over 74 million” (2003, 4). As we can see, despite all government repressions, the number of drug users definitely has not decreased. In absolute values, it is estimated that at the break of the millennium, in 2000, Americans consumed approximately 260 metric tons of cocaine and 13.3 metric tons of heroin and spent \$36 billion on cocaine, \$11 billion on marijuana, \$10 billion on heroin, \$5.4 billion on methamphetamine, and \$2.4 billion on other illegal substances (ONDCP 2003, 2).

In this context, drug prohibition cannot be considered in any way as an effective means for the protection of public health against drug use. Basham writes that “[t]here is not a single empirical study that demonstrates that the social and economic benefits of drug prohibition outweigh the social and economic costs” (2001, 8). This fact is proven very well by Becker, Grossman, and Murphy (2004). On the contrary, drug prohibition imposes other costs on society and creates new externalities. As a consequence of government efforts to protect public health, ordinary people get to an unenviable position. On one side, they have to, thanks to public health insurance, pool their risk with drug users and bear their health care

costs, and on the other side, they have to contribute from their taxes to the futile fight against the drug use. Davis points out that, “[t]he government’s current strategy, by measures of economic efficiency and equity, has been costly and its burden distributed unfairly. Taxpayers fund the explicit cost of drug control and the spillover costs have been borne by parties usually not associated with illegal drug activity. Current attempts to eradicate illegal drugs appear to create the very phenomena they are supposed to correct – spillover costs” (1998, 176). And Ostrowski adds that “[t]he war on drugs is immoral as well as impractical. It imposes enormous costs ...on large numbers of non-drug-abusing citizens in the failed attempt to save a relatively small group of hard-core drug abusers from themselves. It is immoral and absurd to force some people to bear costs so that others might be prevented from choosing to do harm to themselves” (1989). If we summarize it, we have to admit that the only subject who profits from drug prohibition is the government itself and its clerks (the bureaucratic apparatus). In this light, drug prohibition represents a counterproductive, ineffective, and expansive government program which gives the government more control over its citizens, and on the other side, infringes on personal freedom and liberty, just exactly in the line with Higgs’ explanation of the growth of Big Government (see Higgs 1987).

Drug Prohibition as Public Health Regulation: Who Loses?

Drug prohibition caused that the drug business moved from the legal to the black market. As a result of this change, organized crime replaced the supply side of the drug market, the government absolutely lost control over drug production and sales, and drug quality radically changed, which consequently affected the health of drug users. Drug prohibition, which should protect public health against drug use, paradoxically created from drug use one of the most risky activities for human health ever, as it will be described in this chapter.

Let’s take a look at the difference between the legal and the illegal market at first. In the legal market, a product is sold with information. Consumers know the quality of products, their composition and potential dangers of their use; furthermore, they can compare similar products and then choose those which meet their needs best. There are also quality standards in the legal market. As Thornton writes, “[m]arket forces lead to certain industry standards, such as twelve ounces in a can of soda and four rolls of toilet paper per package” (1991, 89). Moreover, competition among suppliers, who want to attract customers by better quality products, ensures these standards as well. In the free market, companies are motivated to continuous innovations regarding product quality.

On the other side, in the black market for drugs, none of this exists. There is no quality control, no information about the quality of drugs, no information about drug composition and about potential risks of their use. The consumers are forced to buy unknown drugs, which are very often adulterated, contain poisons, and are of uncertain potency (Ostrowski 1989). As Thornton points out, “[i]n the black market the potency of a product is not fixed, consumers have less information about potency and added ingredients, and the producers are not legally liable in the same sense as pharmaceutical companies” (1991, 91). Since there is no quality control, drug dealers can, with impunity, produce and sell these dangerous and impure drugs. Drug prohibition thereby increases the chance of accidental poisonings and overdoses by unknown and impure drugs, contributes to the spread of infectious diseases, such as AIDS or hepatitis, among drug users (Miron and Zwiebel 1995, 184), and overall “kills by making drug use more dangerous” (Ostrowski 1989). Moreover, the black market does not allow to use normal corporate strategies and compete by normal means (advertisement, product quality innovations) as in the legal market, and drug dealers, therefore, have to use different means, such as violence, crimes or corruption.⁶

Drug prohibition causes that drugs are lower quality and less safe; therefore, drug users are exposed to serious health risks when using drugs. Instead of protecting public health against drug use, drug prohibition represents the biggest danger for the health of drug users. Ostrowski (1989) estimates that the drugs sold in the black market are fivefold more dangerous than in the pre-prohibition time, and that as many as 80% of the deaths attributed to heroin and cocaine use each year are not the result of drug use itself but are actually caused by black market factors (for example, by an allergic reaction to the street mixture of the drug or by infections). One of the most visible evidence of this change in drug quality can be the case of heroin. Just try to compare pharmaceutical heroin used in medicine with the heroin sold on the street, and you will see certain results of drug prohibition. Doctors can use their prescription-writing heroin and “are able to lead rather normal and productive lives” (Block [1976] 2008, 37), on the contrary, addicted heroin users on the street are very often victims of this impure drug and they look like vagrants.

Moreover, the potency of drugs is positively correlated with the intensity of drug prohibition (see Thornton 1991, 89 – 110). This effect of prohibition on drug potency was empirically proven at the time of alcohol prohibition⁷, and in reality, it is so well-known that

⁶ See Miron and Zwiebel (1995, 177-180) or Benson and Rasmussen (1996) for the effects of drug prohibition on crimes and violence in the black market.

⁷ See Warburton (1932) for the results of alcohol prohibition.

it is called the “Iron Law of Prohibition”.⁸ This law says that “the more intense the law enforcement, the more potent the drugs will become” (Cowan 1986, 30-31). Thornton writes in this context that “[t]he potency of narcotics, cocaine, alcohol, and marijuana increased significantly after the enactment of prohibition. In the United States during the past century, opium was virtually replaced by morphine and, later, morphine by heroin ... The potency of marijuana increased several hundred percent after a prohibitive tax was enacted in 1937” (1991, 89 – 90). Friedman (1992, 4) points out that highly potent and dangerous crack would never have been invented if the growing intensity of the drug war did not make its production and sale more profitable compared to cocaine.

The Iron Law of Prohibition is supported by the fact that the production of less potent drugs is very often much more dangerous and less profitable for drug dealers. Therefore, people interested in the illegal drug business often look for possibilities of producing and selling drugs that are easier to store and distribute. As Mercer proves it, “[p]rohibition is directly related to the potency of drugs. Given the risks involved in circumventing the law, dealers would rather transport the more potent and lucrative drugs“ (2001). Government authorities in the United States are, for example, much more successful at capturing boats carrying marijuana than cocaine or heroin, and that is why many drug cartels in Mexico and Columbia have turned to smuggling these drugs (see Murphy, Waldorf, and Reinerman 1991). This also clarifies, to a great extent, the contemporary situation when various synthetic drugs start to appear (e.g. ecstasy or methamphetamine). These drugs can be easily produced in small home laboratories and their production does not require large outdoor areas. The poppy and coca plantations are much easier to discover by government authorities than these home laboratories, and unlike the production of cocaine or heroin, the production of synthetic drugs is much safer for drug dealers. In contrast, government authorities lose control over the growing number of these small drug laboratories.

As a result of drug prohibition, drugs are adulterated by unknown or dangerous substances, they have unpredictable variance in their potency, and they became much more dangerous for their users. Consequently, it is much harder to predict the effects of their consumption, which can cause a number of serious health problems for drug users and sometimes even the possibility of death. Drug prohibition thus “succeeded” only in making drugs more potent and dangerous substances, losing any control over them, and exposing their users to serious health risks. Moreover, drug prohibition prevents the necessary rehabilitation,

⁸ This term was introduced by Cowan (1986, 30-31) for the first time.

detoxification, and other treatment services for drug users (Basham 2001, 4), and discourages the use of illegal drugs for medical purposes (Miron and Zwiebel 1995, 184). Consequently, drug prohibition represents the worst possible means for the protection of human health against drug use, and this prohibition, paradoxically, “increases rather than decreases the use of publicly funded health care resources” (Miron and Zwiebel 1995, 184).

Conclusion

After analyzing the consequences of drug prohibition, it is time to introduce a possible solution to drugs regarding the protection of public health. As it was described in this article, the government effort to protect public health against drugs has failed. Instead of solving problems connected to drug use, the government creates externalities in drug use. Due to public health insurance, it forces people to pool their risk with drug users and to bear their health care costs. Due to drug prohibition, it forces people to pay for the futile fight against drug use. People who do not use drugs are definitely losers in this government effort to fight for public health. Drug users themselves are in a strange position. Due to public health insurance, they have no economic motivation to stop using drugs because they do not have to bear their increasing health care costs. Consequently, they systematically overestimate present benefits of drug use. On the contrary, due to drug prohibition, they are exposed to serious health risks when using unknown, more potent and less quality drugs. As a paradoxical result of government intervention, they are motivated to use more drugs which are more dangerous for their health. That is the real effect of government regulation aimed at protecting public health against drug use. The only winner of this effort is the government itself, which gains more control and power over its citizens.

The solution to drugs, which will be suggested here shortly, is just focused on eliminating government power and government externalities in drug use. If we want to remove public health externalities resulting from drug use, we have to touch the real reason of their existence, which is the system of public health care and, specifically, public health insurance. The return of health insurance, which would be subject to market principles, has to be the first step leading to the elimination of externalities in drug use. As Hoppe writes, “[t]o deregulate the insurance and in particular the health insurance industry means to restore it to unrestricted freedom of contract: to permit a health insurer to offer any contract whatsoever, to include or exclude any risk, and to discriminate between any group of individuals.

Uninsurable risks would lose coverage and be returned into the realm of individual responsibility” (1997, 474). Health insurance in the free market would have an irreplaceable function in eliminating externalities in drug use because of a re-entry of economic calculation into the provision of health care. Private insurance companies are very good at identifying health risks resulting from drug use, evaluating these risks, and charging adequate insurance premiums for this danger activity. They would probably charge higher insurance premiums to drug users because of higher risk of their health problems in the future or, in some cases, they could refuse to insure these people. In the free market, there is obviously no right to health. If someone damages his own health by using drugs excessively, he has no right to get free health care. However, people would regain the freedom of choice. The use of drugs would be connected with higher economic costs but everyone would have a choice whether to pay these higher costs in exchange for this pleasure or not. People who use drugs would know that they are responsible for their behavior and that they act at their own expenses. They would finally bear health care costs of their own behavior. Consequently, all external health care costs of drug users would become private costs and would not be anymore carried by society as it happens nowadays. It is also important to note that these health care costs of drug users would definitely be much lower than nowadays because of better quality, less potent and less dangerous drugs selling in the free market. And last but not least, the return of the market mechanism and personal responsibility into health care (with the irreplaceable function of private insurance companies) can be considered as a means that would limit the growth of government power. In the free market, nobody would have a need to persecute and imprison drug users for their behavior, nor would anyone be willing to pay absurd amounts of money to fight against drugs. Eventually, the government would have “to admit that [it is] not God, that [it] cannot live other people’s lives or save people who don’t want to be saved” (Sowell 1989). Instead of the government, personal liberty and responsibility would return to drug use.

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