Single-Payer Health Care in America:

Prescriptions and Effects

Kyle Burko

Dr. Herbener

ECON 420

22 January 2014

I. An introduction to healthcare: voluntary systems vs. government coercion

“The government pretends to be endowed with the mystical power to accord favors out of an inexhaustible horn of plenty. It is both omniscient and omnipotent. It can by a magic wand create happiness and abundance” (Mises, 1944).

In the above words from his work *Bureaucracy* (1944), distinguished Austrian school economist Ludwig von Mises claims that the principal argument used by government to advance its aims is the false one that it can create wealth for everyone without negative effects. His perspective on the central issue behind the healthcare debate is important in establishing the distinction between a voluntary system of healthcare and a publicly funded, or single-payer, system of healthcare as we see in the Canadian system and the new United States system under the Affordable Care Act (2010).

The key difference between a pure system, which can have both public and private elements, and a bureaucratic system, is in the origination. The former arises on the free market as a result of consumer demands for healthcare to cover both routine visits and the more rare symptoms of diseases and illness. The latter arises as a result of government decree and is inconsistent with the demands of the free market. In nearly all countries today, healthcare has become socialized to some degree. This means that health “insurance” plans are offered by the government to citizens regardless of employment status or their own private plan. The health insurance provided is funded at least partially by coercive levy, or taxation. The single-payer system is often touted as a way of providing healthcare coverage to everyone within the economy at an affordable price. This socialized, or single-payer, system is claimed to be better than a privatized system because it does not withhold care from the needy if they do not have the ability to pay. It is important to first look at these claims at the theoretical level to see if they hold up to the scrutiny of economic analysis. Each of the three main arguments will be examined in turn.

The first main claim of proponents of single-payer systems as can be seen in the case of the Affordable Care Act in the United States is that it provides guaranteed health insurance coverage to citizens who may have been previously been denied coverage due to preexisting conditions or simply inability to afford the services. This includes access to emergency services without requiring the approval of an insurance company prior to the care being offered. This serves to narrow the inequality gap between the wealthy, who receive special privileges in medical care, and the poor, who receive a much lower proportion of the health care relative to their proportion of the population in the United States.

The second area of proposed benefit is in restrictions on limitations by insurance companies after implementing the single-payer system. Insurers are now unable to place dollar limits on insurance policies over a person’s lifetime. Additionally, insurers are unable to cancel policies if a person becomes sick or to deny coverage due to preexisting conditions.

A third and final proposed benefit of single-payer healthcare systems is that it lowers costs overall, cutting away at the excessive costs associated with privates systems. Economists such as Paul Craig Roberts cite numerous burdens of the private system such as expensive medical technology, malpractice lawsuits, third-party costs, and high executive salaries in insurance companies. These costs, which are viewed as extraneous problems with the free market, can be done away with a single-payer system (MacKenzie, 2009). A single-payer system can “take the profit and paperwork out of healthcare” (Roberts, 2009).

Each of these three claims of nationalized healthcare will be discussed within a theoretical framework grounded in the Austrian economic theory of Ludwig von Mises and Murray Rothbard. These three arguments listed above form a three-legged stool that is the bulk of the support for a nationalized, single-payer health care system. In the United States politicians usually stand on at least one of these three legs to support their policy prescriptions, particularly with the new Affordable Care Act which was signed into law March 2010. A key nuance to the health care debate in the United States is that there is no real example of a privatized system to compare with the system which will be implemented under the Affordable Care Act. Thus, it is important to examine the issue theoretically in order to avoid the mistake of looking at a country whose health care system contains elements of both a private system and also of a socialized system and assuming that this country’s system is either wholly socialized or wholly privatized.

Examining the first benefit requires the ability to look past the immediate promises of the health care policy, regardless of country, and understand the market for health care that exists and how it will respond to the policy’s practical changes in supply and demand. The push for national healthcare is successful politically because of its ability to effectively turn what is usually considered a privilege—access to quality health care—into a right which is access to “free” care.

The effects of fully socialized healthcare were seen in the late Soviet Union where health care becomes a legal “right” for all citizens, but the *de facto* result of the policy is either no access to care at all, or inadequate care if a physician visit is afforded. According to Professor Yuri Maltsev of Carthage College, the Soviet Union became the first country to offer complete, universal health care coverage in 1918, and the claims made in favor of the plan were strangely similar to those used today in America: the new legislation will somehow “reduce costs” and eliminate the “waste” (read: excessive profit) resulting from competition on the market (Maltsev, 2012). According to Maltsev, a popular saying among medical personnel was “They pretend they are paying us and we pretend we are working.” By 1921, Communist party officials realized that they could not be a part of the socialized medical system as the conditions under it were not nearly as pleasant as they expected. The conditions in the country’s medical system failed to develop on par with many other countries, and the country’s birth rate suffered tremendously at 24.5 deaths for every 1000 live births compared with a rate of 8.1 deaths per 1000 live births in the United States. Even after the Soviet Union had expired in the late 1980s, the infant mortality rate was about 2.5 times worse than the United States and 5 times worse than Japan in total (Matlsev, 2012).

At a basic theoretical level, the creation of a “right” to health care creates a sudden upshot in demand for medical services as soon as the uninsured are able to successfully register for the government list of enrolled persons. This surge in demand does not produce for itself a miraculous compensating supply of medical personnel to fill the demand, and thus creates a case of excess demand in the healthcare market where the formerly uninsured citizens are now able to demand health services without footing the bill directly, aside from perhaps a small deductible at the time of service. The excess demand for care relative to the market of medical services from physicians requires either long lines in hospital waiting lobbies, or a system of rationing care in order to confer the benefit of exclusive service in time of need to some at the expense of the other. A scapegoat is placed for politicians who are often entitled to keep the government health plans that they held previously or enter a special category in the new system. An example of this type of political exemption is present in the Affordable Care Act to allow members of Congress to receive employer subsidies contributing to their coverage plan on the federal “Obamacare” exchange of health care services. In addition, a special rule was passed in September to allow members of Congress to remain off of the federal health care exchange altogether, keeping their current plans (Vitter, 2013).

Thus, nationalized healthcare effectively places a new requirement on health professionals to provide for non-paying entitled without providing the increased supply of medical care needed to meet this demand. Further, in the U.S. system, small businesses are required to provide health plans in compliance with the Affordable Care Act to their workers or face incredible fines.

The second main benefit proposed by supporters of the single-payer health care system is that of granting health insurance to millions of those citizens who are currently not covered, regardless or preexisting conditions or occurrences of illness. In the United States, the Affordable Care Act. Economist Robert Murphy provides a basic overview of the legislation as it pertains to insurance:

“Insurers are legally required to provide coverage to all applicants, regardless of medical history, with a partial "community rating” system for premiums, which means that insurers must set premiums based (mostly) on geography and age, rather than sex and (most) pre-existing conditions” (Murphy, 2013).

Additionally, these health insurance policies are restricted from having caps on lifetime payments per customer per insurance policy. This health coverage becomes universal as everyone is required to obtain insurance with few exceptions (religious groups, etc.) (Murphy, 2013). The result of this enlargement of the health care pool is fully predictable, and the effects are not nearly as pleasant as forecasted. In first extending the grant of universal coverage *alongside* existing private employer-funded health insurance funds for its full-time employees, the issue arises as to which employers will choose to pay the extra expense of their private health insurance fund when their business comes into tough financial times. The temptation is to allow the existing contracts to expire without renewal in favor of having employees enroll for health insurance with the “state exchanges” as the Affordable Care Act pledges to create across the U.S. The reaction to this anticipation was for the federal government to create a mandate for employers to provide full-time employees (defined as those working 30 or more hours per week) with expensive plans spanning a variety of care types, regardless of the company’s issues.

One of the principal effects of the new mandated health insurance for employers is systemic lay-offs or reduction of hours among companies that are marginally profitable. These companies, riddled with the new and uncertain expense of providing healthcare to all of their fulltime employees (more broadly defined at 30 hours versus the usual 40 hour definition), will be forced to find legislative loopholes, propose being a religious institution and therefore exempt from providing coverage, limiting employees to part-time employment, or shutting down altogether.

The third and final claim of those favoring single-payer systems is that overall costs of the medical industry will be cut down somehow by limiting executive salaries, malpractice suits, and expensive medical technologies. This claim of proponents is often unsubstantiated, relying on an argument against “corporate waste” or the entangled interests of physicians with big insurance companies.

Part of this cost cutting argument is clearly true, but the nominal cutting of costs in some areas, such as medical equipment and pharmaceuticals, may cost more money and ultimately lives as a result of the prolonged nature of some illness which could be cured more quickly. As pointed out by Dale Steinreich, economics professor at Drury University, the number of CAT scanners is much higher in the U.S. compared to Canada and Britain. In 2007, the ratio was about three to one in favor of the U.S. The up-front cost of the scanners and their usage is higher in the U.S., but the simple medical service provided by the scanners is overlooked: CAT scans offer a cross-sectional look at the body within the machine in order to show diseases and their effects on the body much more effectively than a traditional X-ray scan or MRI scan. The effectiveness of the CAT scan is evinced by their proliferation in hospitals to replace traditional means of examining the body. The cost is certainly higher, but the effectiveness of finding diseases with CAT scans is far greater than those of traditional X-ray scans of yesterday.

This is simply an example, but Steinreich describes an unexpected outcome of *technophobia*, the fear of adapting new technology in a socialized or single-payer health care system (Steinreich, 2006, p. 77). The number of patients in need of cutting-edge technology and expensive treatments are generally far outnumbered by those patients with simply medical demands such as common cold and bronchitis, vaccinations, and regular examinations. The latter group chooses perks for themselves over investments in longer-term technologies for those few in need, and politicians pander to the latter group at the expense of the former (77).

According to Steinreich, practically, the ability to cut down costs with a single-payer system has not been substantiated by examples such as Canada, whose health care cost increases are second to the U.S. without including the cost of medical buildings and equipment which are classified as government expenditures (78). Part of the high cost as seen in a comparatively free-market country of the United States are in fact due to bureaucratic restrictions on the medical field, making it more exclusive then it could be if unregulated, and limiting the supply of medical services. Restrictions in the form of “certificates of need,” licensing requirements for physicians, and other limits of medical solutions lead to inefficiency and drive up the costs in America. However, the amount of funding spent on medical procedure in the United States is not entirely an economic malaise to be corrected. In part, executives in the large insurance companies as well as physicians are providing consumers with exactly the kind of care they are looking for, and with little waiting time. High profits are in part a result of satisfying the consumer and controlling their own costs.

It is difficult to see theoretically how a single-payer system would cut costs while at the same time delivering the high level of care that health care consumers have come to expect in such highly developed countries as the United States. There are other causes of excessive health care spending in the United States that are completely unrelated to free market operations, but are actually a result of financing through insurance, nominally labeled, because per-service fees remove some of the problems inherent in the muddied insurance system of present.

II. Theoretical arguments on free market health care and socialized healthcare

In his 1995 book, *Making Economic Sense*, Murray Rothbard gives some introductory thoughts on healthcare that illuminate the reality behind the “smoke and mirrors” that is often perpetuated on the political stage. To start, medical care is difficult to define because what is considered care in one country, China for instance, would be considered neglect or malpractice in a country with a more developed medical system such as the United States (Rothbard, 1995, p. 75). Thus, the political use of the term “health care” is often inadequate when arguing for or against certain systems. What is truly of importance is the incentives and motivating forces within the system that will either lead to better quality or lower quality care. It is truly the incentives that are of utmost importance. A pure insurance system is defined as a pooling of risk among similar-risk claimants who have a similar level of uncertainty for incurring a given condition. The insurance system operates well under two conditions: the pool of insurance claimants must be capable of grouping by the insurance company due to similar risk status. And, the insurance claimant must not be capable of triggering the payout from the insurance company by his own choice. Ultimately, the insured event must be unpredictable and unaffected by the insured’s actions. Examples of pure insurance include packages against natural disasters which one could certainly not cause, insurance against theft, and health insurance against unforeseeable conditions.

Problems arise in an insurance system whenever the insurance payouts become predictable or the insured person can effect the event that is supposedly an uncertain risk from the perspective of the insurance company. An example of this would be a person wishing to live in a new house and subsequently burning his own house to receive the payout of his natural disaster insurance plan.

Health insurance is naturally a poor choice for socialization because a person’s lifestyle habits and risk taking have an impact on how often he must receive medical attention. When one receives the insurance plan, there is an increased incentive toward laziness regarding personal health since bad health outcomes will be remedied at the insurance company’s expense when the need arises (Rothbard, 74-75).

In following the logical flow of thought, government medical insurance actually leads to the very high prices that are sought to be extinguished in the single-payer system from the outset. The reason for this is that there is no inhibition built into the single-payer system that can limit expenditures per person or procedures per person. When doctor visits become nearly cost-less for the patients, more frequent doctor visits become normal and expected. However, in order to keep up with this new demand curve which has artificially risen, medical “care” takes a serious hit in quality. Even in the United States, there is still some memory of health care before health insurance got its foot in the door, and the personal, intimate house calls of doctors were replaced with a more mechanical, assembly-line care model (Rothbard, p. 76).

Even the origins of employer-provided health insurance were artificially-conceived as a result of a 1943 tax policy which made these insurance plans tax free. This occurred during World War II in the face of wage and price controls which forced many industries to compete in non-price ways. Offering higher wages was not possible, so health insurance plans stepped in to fill the void that free market negotiation had occupied (Vijay Boyapati, 2010). By 1954, the benefits were increased and entered into law in the Internal Revenue Code. Since 1940, the number of employees receiving health insurance from their employer rose about 15,000 in 1940 to nearly 130,000 in 1960. This system of healthcare in which a third-party (insurance companies) received payments from consumers instead of direct payments for each service resulted in a model of medical industry that encouraged prices to skyrocket at the expense of consumers and employers. Like an all-expenses-paid business trip, the incentive is to enjoy the best services possible when you are not paying the bill directly. This leads to the upward trend in costs as a result of employer-provided health insurance.

The question arises as to why business do not keep insurance premiums low if they have any say in the matter. However, the issue of privacy of care keeps employers from pushing back against rising health care costs. In the face of rising costs due to insurance premiums, employers tend to drop other benefits for their employees instead because they are not able to stoop into the private affairs between doctor and patient that are confidential. Thus, the rise of medical insurance was not actually a result of the free market but of government intervention to encourage employers to get started on an irreversible trend. Once an employer offered health insurance coverage, it became increasingly difficult to drop the plans because employees had become so used to and dependent on the support.

From a traditional Austrian perspective, health care must in fact be a free market exchange in order to maximize efficiency and provide the highest quality of care. Despite the general consensus that the U.S. was an example of privatized health care, (prior to the 2010 legislation) there are many elements that separate it from a truly private system. In a truly free system, health insurance would most likely be sharply limited, and would only insure against far-cry risks which could not be detected from the scanning and imaging capabilities available in the medical field. Since true insurance must deal with unknown risks, routine appointments and other foreseeable illnesses would not be insurable. The patients would always self-select into those plans that offered a lower deductible and premium total than they would face if paying their own medical bills out-of-pocket.

The solution to many of the above listed problem with health care both in the U.S. and around the world has more to do with the level of government involvement in the industry than anything else. Examples of free markets in health care provide a rare look at the operation of the economy in the absence of government interferences such as socialized insurance, legal restrictions on practicing in the medical field, and limitations on use of approved medicines and technologies.

For the remainder of my paper, I will look briefly at an example of a highly socialized market in the twenty-first century U.S. and at an example of a more free market in the pre-World War II U.S. health care system. These examples will provide a look at how health care operates both with and without the interferences of the federal government and how the outcomes match up with those under a fully socialized system.

III. Case study: the United States before and after World War II.

For those interested in studying the impact of government involvement in the health care industry, the example of the United States before and after World War II helps to illuminate some of the distinctions between a largely private system and today’s tangled system with numerous competing third-party interests and an uncertain degree of consumer satisfaction as a result. Indeed, the main institutions of the American Medical Association, the Food and Drug Administration, and the links between health insurance companies and the federal government have had a substantial impact on the supply and demand of health care services in the U.S. as well as on the forms that physician services have taken over the years. In addition, prices have increased dramatically since World War II far beyond the rate of inflation of the dollar.

While the overall medical field was less developed than the one we have today, the market was much freer for innovation and entrepreneurial activity which had many benefits for both physicians and health care users at the time. Before the 20th century, health insurance had not yet been conceived, and many people would not voluntarily go to a hospital. Hospitals did not safely contain diseases, and visits to them often resulted in unrelated illness and sometimes death.

Clark C. Havighurst, Professor of Law at Duke University School of Law, argues that the underlying problem of the American health care market is the substitution of private contracts with health insurance with disastrous consequences (Havighurst, 1995).

Havighurst recognizes the hindrance that insurance companies place on the physician-patient relationship. Health insurance suffers the fatal flaw of permitting the “moral hazard” by encouraging excessive use of care at the expense of the less risky payers in the health care tax base. The fundamental argument is that when purchasers on the free market contract for a delivery of goods and services, the purchaser puts into writing his will for the goods and thus conveys personal expectations from the seller (Havighurst, p. 148). Within the American system, however, this sort of natural communication is not present and is stifled by the dominance of third-parties that do not disclose their terms specifically, but only generally.

Private health plans that are prepaid fail to specify the terms and services that will actually be delivered. This harkens back to Rothbard’s point of “medical care” being a slippery slope because of the inconclusive quality of the care that is being agreed to in prepaid health plans, primarily in single-payer systems that narrow the classes of the insured at the expense of the insurer. What is important is the lack of the providing of specific care that the patient needs and which can only be delivered by an intimate relationship between the doctor and patient. Today’s system in the United States relies primarily on private health insurance companies, the market-leader being Blue Cross Blue Shield Association. However’ the reason that the insurance system has become dominant in the United States has much to do with early encouraging of business competition based on health benefits during World War II, and thus it is unclear whether consumers would choose this system of their own accord. We have been grandfathered into a system with little transparency as the costs of private health care and doctor services have gone through the proverbial roof. Today, many families cannot afford to pay medical bills without the aid of the insurance system (147-148).

As Havighurst points out, health plan contracts “are more in the nature of insurance policies than contracts for the future delivery of services” (Havighurst, 149). The role of physician becomes distorted in this system of contracts as health insurance companies agree to pay for whatever services the physician recommends within broad categories of care. This fails to correlate the system of payment with the actual services rendered. Current contracts operate on the test of “medical necessity” which enshrines the prescriptions of health care providers with little regard for the financial means and specific needs of the consumer-patient. Inherent in the American system is a disguising of the costs and benefits for services beneath the authoritative cloak of “medical necessity” that cannot be challenged by politicians as it lies outside their field of knowledge and must be decided by “experts” in the fields. What is untold is that physicians should not be the ones making cost-benefit decisions for their patients. Only the patients themselves and their close family members are prepared to and capable of making the difficult decisions regarding what form of care is chosen.

Another issue distinct from that of costs is that of the quality of care in the American system. We have already established in this section that the U.S. health system has the incentive toward high costs and excessive use of the health care system with socialized insurance. What would an ideal health care system look like? Most consumers would say one in which doctors truly care for their patients and are compelled to deliver the care which would best help the patient or lose his business. Physicians in this ideal system would know much about their patients from thorough examinations and repeated interactions over the years of the patient’s life. The physician would have at his disposal the tools and medicines needed to serve the consumer and would be unrestrained in his use of them as he and the patient sees fit.

Instead of allowing physicians free rein over their care prescriptions and methods of care, the federal bureaucracy via the U.S. Health Department places myriad restrictions on physicians, hospitals, and health plans. Sanctions are held over the head of physicians who decide to administer drugs not approved by the FDA or in amounts deemed excessive or in violation of numerous other rules.

The third main area of government interference in the U.S. health care industry is in the field of licensure and medical practice. The main arm of this bureaucracy is the American Medical Association (AMA) which governs the field of licensure by, first, approving medical schools in the U.S. based on the requirements of their M.D. programs, second, by limiting the competition for approved physicians by routing homeopaths, nurses, and later chiropractors in the market in the 19th century (Steinreich, 2004).

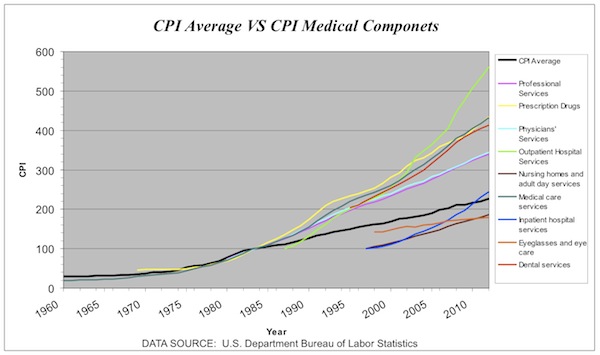
It is important to mention, however, that limiting the field of physicians who can legally practice medicine is not inherently bad. We can envision ways in which the free market would form voluntary associations of doctors and physicians who agree to a codified set of practices and procedures and place their “stamp of approval” on any physician who practices within the codified law. There could be periodic checks on these physicians and expansion or amendment of the code over time to include new medical technologies that are demanded by consumers. As long as this organization of physicians was not subsidized by government funding (presumably from tax revenues), the organization’s limiting of the “approved” physicians in the market would be in the best interest of the consumers.

The issue arises when the organization that sets licensure requirements is directly in league with the federal government and is operated not according to the wishes of the patient-consumers, but according to the public policy of a bureaucratic government arm such as the AMA. Between 1904 and 1910, the organization shut down about 35 medical schools in the U.S. This fact alone leads to no clear conclusion. By 2002, the AMA had succeeded in lowering the number of medical schools in the country by 26% since 1900 while the U.S. population had actually increased by 284%. The selectiveness of the schools alone presents no issue, as we would assume that only the cream-of-the-crop students were being admitted to the top medical schools. However, in the late 1990s, the Center for Equal Opportunity surveyed six medical schools and found that more than 3,500 Caucasian and Asian students who applied were denied admission despite having higher academic and MCAT credentials than Hispanic and African-American students who applied at the same schools (Steinreich, 2004). Instances of “affirmative action” or other biased admission standards pose a stark affront to the quality standard that is supposedly upheld by the AMA. The exclusion of qualified students due to their not being a certain ethnicity leads to the conclusion that political, rather than academic considerations have been chosen by the AMA as the criteria for medical school admissions. This would not occur on the free market.

IV. Health care conclusions

In the United States, private health care systems have not been seen since the late 19th century prior to the effective unionization of the medical profession and its physicians. It is difficult to compare the effects of that period with the present health care dilemma because of the complexity of institutional changes and the dramatic advances in medical technologies and pharmaceuticals that have made many fatal diseases such as diphtheria, malaria, measles, and polio a thing of the past. However, the prices of health care have risen dramatically as well, far beyond inflation. As shown in Figure 1 from the U.S. Bureau of Labor Statistics, since 1990 has recorded a rise in “Outpatient Hospital Services” and “Medical Care Services” far beyond the Consumer Price Index. This leads to the conclusion that somehow the health care industry has seen skyrocketing prices.

**Figure 1: Medical Service Inflation Measured against CPI, 1960 - 2010**



The claims of those in favor of single-payer health care systems seem rooted in misunderstanding of the incentive system that is operative in a free market health care system and in a socialized one. In the socialized system, no matter how willing or capable doctors are, their role in judging patients needs is secondary to the demands and restrictions placed on their conduct by the government’s medical infrastructure. This infrastructure must be generalized and involve grouping patients into artificially relevant categories, such as age and location which are only influence one’s medical condition to a small degree. The government simply lacks the abundance of specific information about patients that is needed to make an informed decision about medication, surgery, and other general health maintenance prescriptions that patients need. In the socialized single-payer system, however, customers are given more generalized treatment because of efficiency needs in the system. With many more patients in waiting rooms awaiting care, the amount of time per patient will decrease, and only those patients who have sufficient time to wait will be able to receive care. This has the effect of creating a reordering of the market in which those patients with lower time values and a lower time opportunity cost in waiting for care will receive care while those patients with a higher time opportunity cost will need to find care elsewhere—in other countries, or from the black market. An example would be a businessman and an unemployed man waiting to receive a routine health check-up. If both the businessman and the unemployed man are lumped into the same insurance class, they will wait in the same line for care. However, due to his position, the businessman gives up all of the wages and other benefits he could have received had he spent the waiting time in his workplace. The unemployed man may miss out on spending time with friends or family, but the actual wages lost in waiting is far less. Thus, the unemployed man is able to wait longer than the businessman, likely resulting in the businessman finding a provider who can deliver the service more quickly and the unemployed man receiving service on the public health care exchange market.

The result is that only those with less to lose by waiting remain within the public system of health care.

The effects of the single-payer system are to drive up prices rather than drive them down because the government does not have the same incentives as private firms to keep costs down. If costs rise, it can simply raise taxes and pay the new, higher cost. The single-payer system effectively takes from the healthy by forcing them to pay into an insurance system when they do not need insurance themselves; their personal health risk is very low. Those in the system receive lower-quality care because more care is offered without commensurate price, and doctors must appease patients to some degree to avoid rioting. The proposed system is an example of the proverbial emperor who has no clothes. It is touted as a magic garment that will provide care for everyone who needs it, while in fact, no additional care is created. What is created is longer waiting lines, lower-quality service, physicians dropping out of the market due to stress and overwork, and a strained system falling to shambles as a result of political solutions that lack any backing in sound economic reasoning.

Bibliography

Boyapati, Vijay. 2010. “What’s Really Wrong with the Healthcare Industry.” Ludwig von Mises Institute. Available at <http://mises.org/daily/4434>.

Feldman, Roger D., ed. *American Health Care: Government, Market Processes, and the Public Interest.* Oakland, CA: Transaction Publishers, 2000.

Havighurst, Clark C. 1995. *Health Care Choices: Private Contracts as Instruments of Health Reform*. Washington: AEI Press.

MacKenzie, D.W. 2009. “Understanding the Costs of Healthcare.” Ludwig von Mises Institute. Available at <http://mises.org/daily/3708>.

Mises, Ludwig von. *Bureaucracy*. New Haven: Yale University Press, 1944.

Murphy, Robert. 2013. “The Economics of Obamacare.” Ludwig von Mises Institute.

Available at <http://mises.org/daily/6587/>.

Roberts, Paul C. 2009. “The Health Care Deceipt.” *Counterpunch.* Available at

<http://www.counterpunch.org/2009/09/14/the-health-care-deceit/>.

Rothbard, Murray. *Making Economic Sense*. Auburn, AL: Ludwig von Mises Institute, 2007.

Steinreich, Dale. 2004. “100 Years of Medical Robbery.” Ludwig von Mises Institute. Available at <http://mises.org/daily/1547>.

Vitter, David. 2013. “Washington’s Obamacare Exemption.” *National Review*. Available at [http://www.nationalreview.com/article/359020/washingtons-obamacare- exemption-david-vitter](http://www.nationalreview.com/article/359020/washingtons-obamacare-%09exemption-david-vitter).