The Case for a Regulated Drugs Market

Robert E. Marks

***Robert Marks**, a Senior Lecturer at the Australian Graduate School of Management, argues that the social costs of prohibiting drugs far outweigh the social benefits, and supports the Cleeland Report's (1989) recommendation of a regulated drugs market.*

AT the special Premier's 1985 conference on drugs — the so-called drug summit — the Australian Commonwealth, States, and Territories agreed to spend $120 million over the following three years on the National Campaign Against Drug Abuse. Of this amount, $24 million was allocated specifically to improved police and customs surveillance and detection; the balance was allocated to programs of treatment, education, and rehabilitation.

Lack of data on the pre-existing situation means that the effectiveness of the campaign cannot be clearly measured, although some resources are being spent to remedy this lack — perhaps for future campaigns. The recent publication *Drugs, Crime and Society* (Cleeland Report, 1989), presents the most recent information on the scope and nature of the trade in illegal drugs in Australia, and on the social costs of the present policy of prohibiting the production, possession, use, supply, importation and exportation of illegal drugs.

For over 15 years policy analysts have been asking what the goals of the prohibition of certain drugs are. Is the main goal to reduce the numbers of users at any cost? The Cleeland Report (p.91) suggests that an alternative aim of drug laws should be to minimise self-harm, with an emphasis on safe use, rather than the apparent punitive goals of the present laws, with their extremely high costs both for the drug user and for society at large.

In this article I adopt a policy framework that considers the balancing of social costs and social benefits. I argue that the social costs of the policy of prohibition far outweigh the social benefits of the policy. I conclude that a regulated market in drugs would be preferable to the lawless *laissez-faire* of the existing markets, in which the apparatus of the criminal-justice system performs as a kind of de facto price-setting mechanism for the black market.

This utilitarian framework is but one approach to the issue. A different argument is based on the libertarian premise that so long as an activity, such as drug use, imposes no costs on others, then there is no role for the paternalistic state to attempt to control or prohibit it. To do so diminishes the freedoms of citizens to behave as they wish, including choosing their own paths to hell. (However, I believe that drug use does not invariably result in damnation, secular or otherwise.)

A survey of the costs of prohibition is followed by a discussion of policy options involving decriminalisation of drugs. But first I summarise the available evidence about the scale of heroin use in Australia.

The Scale of Heroin Use in Australia

Despite the increasing interest in this issue in Australia in recent years, and the expenditure of many millions of dollars of taxpayers' money on parliamentary inquiries and royal commissions, there are no reliable estimates of either the numbers of heroin users or the social costs of their drug use. Virtually no empirical studies have been undertaken. A document prepared for the drug summit by the National Information Service on Drug Abuse (1985) concluded that there had been little change in overall levels of the legal use of narcotics in the previous ten years. The document stated that there was no reliable evidence to allow an estimate of the number of heroin users, and that no firm estimates could be made of the quantities of illegal drugs used, including heroin. Indeed, there are not adequate data, even at State level, on the numbers of people using drug treatment services, as an indicator of overall drug use. In the absence of such data, the size of the problem must be inferred from health and crime statistics.

A NACAIDS (1988) study concluded that 5 per cent of adult Australians had injected (illicit) drugs at some time in their lives and that 2 per cent had injected over the twelve-month period of 1986-87. For an adult population of twelve million, this corresponds to 600 000 who have ever injected, and 240 000 who have recently injected: figures much larger than those quoted below, perhaps corresponding to a large population of occasional drug users.

The occasional user is in general someone who can control his or her use of the drug, perhaps going on an occasional binge, but no more becoming an

addict than the social drinker becomes an alcoholic. The public image of the heroin user — recently reinforced by the lurid anti-AIDS advertisements — is of the derelict junkie shooting up in the gutter. The occasional users, since they have not in general come to the attention of the police or the medical services, do not conform to the picture of the typical heroin user, and indeed have, until recently, been overlooked by the professional commentators. But since they

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control their heroin use, they impose no direct cost on the taxpayers, unlike the addicts. In this case, what reason is there to be alarmed at their numbers or drug use per se? Concern, if any, might be justified if their casual use and needle-sharing posed a public health risk.

There has been a steady increase in four indicators: New South Wales heroin users, morphine-type dependency deaths in NSW, opiate-related convictions in NSW, and Australian opiate-related deaths. All tripled over the period 1980-85. The series that has risen most smoothly since 1978 is that for opiate-related deaths. On the basis of this series, and given the confounding influences on the other series, we shall work with a figure of 20 000 regular users of heroin in 1983.

Research carried out for the Cleeland Committee reveals that the total number of heroin addicts is up to 12 000 Australia-wide, with no more than 3360 addicts actively using the drug at any one time (Cleeland Report, p.ix). This is fewer than our estimate, but the Committee argues that its figures are consistent with the limited avenues that heroin users have to finance their drug use. We would argue that the large number of occasional users, who use small amounts of the drug and can therefore afford, in general, to pay a higher price for their less frequently made purchases, might well be used by the user/dealers to finance their habits, so that the limited avenues for other income may not be the barrier to larger numbers that the Committee asserts. If the Committee's recommendations for better data collection are acted upon, this uncertainty may be resolved.

The Costs of Drug-Related Crime

As many authors have argued, the policy of prohibition restricts the supply of the illicit drug, which in the face of the inelastic demand for heroin results in high prices. This creates an incentive to flout the law by supplying drugs, which also results in an increase of crime by the drug users, apart of course from their illegal possession and use. The difference between the buying price of a kilo of 80 per cent pure heroin in Hong Kong ($12 000 to $15 000) and its landed price in Australia ($200 000 to $250 000) is clear evidence of the profitability of importation.

The burglaries and thefts associated with drug use are indirectly paid for by all residents of Australian cities through rising insurance premiums. Nonetheless, the crimes associated with illicit drug use are serious, and not simply property crimes. The existence of a profitable black market leads to the consolidation of organised crime, undesirable police practices including corruption, the regressive burden on the poor who live in areas of high addiction, and the pressures on doctors who might legitimately want to prescribe these drugs.

Controlled supply of heroin of known purity and strength would eliminate the motivation for drug-related corruption in law-enforcement agencies and low prices would eliminate the wherewithal for this corruption.

Direct Costs

The Cleeland Report (p.76) estimates a direct annual cost of $123.2 million for the prohibition of several drugs (including cannabis, cocaine, and amphetamines, as well as heroin), a figure which includes the direct anti-drug operational costs of the law enforcement agencies and the costs of legal procedures and in more serious cases the costs of imprisonment. It does **not** include the law-enforcement costs in relation to offences committed by illicit-drug users in order to finance their drug consumption. It does not include capital costs of new prison accommodation (estimated at about $200 000 per high-security cell). Nor does it include the crowding costs and delays occurring in the courts because of drug-related cases. If the costs of indirectly drug-related crime are included, the cost is at least $900 million annually.

Health Costs

The figures for hospital morbidity from drug use are woefully incomplete, but the AIDS pandemic has provided the impetus for many groups to question their support of the prohibition of illicit drugs in general, and of heroin specifically. Because the effect of needle-exchange schemes is limited, AIDS experts have proposed that a pilot project should be established to evaluate the provision of injectable substances to intravenous drug users (IVDUs) in a single-use syringe in carefully selected cases

(NACAIDS, 1988: para.27). The social costs associated with AIDS are difficult to put into figures, but have been conservatively estimated to be $22 billion over the period of the pandemic (Coe, 1987).

There is evidence that a program of prescription drugs in Liverpool (where prescribing them is legal) has checked the spread of HIV infection, certainly when compared with Edinburgh, where, in the absence of any doctors prepared to prescribe, HIV infection among IVDUs grew from nil in 1983 to 51 per cent in 1986 (Cleeland Report, p.84).

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Unfortunately for the moralists, changing people's behaviour is much more difficult than altering the environment in which they live so that their actions are less harmful to themselves and to others.

High Prices and Administration of the Drug

The high prices of the illicit drugs (a consequence of the prohibition and attempts to enforce it) have a further effect. In Vietnam and in Hong Kong, when increased enforcement resulted in higher prices, users were observed to change their method of administration from snorting and smoking to the more cost-effective method of intravenous injecting, with the concomitants of greater risk of infection through shared needles, as well as other risks of disease (collapsed veins, thrombosis). There is some evidence that when the price falls, this is partly reversed, but, once over the hurdle of feelings of revulsion towards self-injecting, users may not always want to revert to other, less effective methods of administration.

The Costs to the Individual User

The costs estimated above may be classified as costs to society as a whole. The costs to the individual user are not so easily handled, but it can be argued that the attempted prohibition has severely increased these costs as well. They include: ignorance of the purity and strength of the street heroin, the risk of apprehension and gaol, and the risk of infectious diseases from sharing needles. To reduce the public health risks, governments have instituted needle-exchange schemes for civilians, although not yet for prisoners. This shows the way forward: with a supply of legal, low-cost heroin, these costs would largely disappear for the existing user.

If illicit heroin consumption is the problem, then eliminating heroin use entirely (whether by effectively enforcing the supply-side prohibition, or by eliminating the demand for heroin use) is a policy alternative to legalising all heroin use. To advocate legalisation is to believe that legalisation is easier or less costly than elimination and to believe that legalisation will not change other objectives of society. Australia has tried elimination of heroin use with the prohibition. It has been a costly failure. Now is the time to consider a radical departure: decriminalisation of the market for heroin.

Prohibition or Regulation?

In response to the costs outlined above, the Cleeland Report suggested seven different responses (pp.91-116):

- tougher penalties;
- de facto decriminalisation;
- de jure decriminalisation;
- prescription of currently illegal drugs to registered drug users;
- licensing drug users to enable them to purchase over-the-counter drugs, while at the same time being monitored;
- commercial supply of the illegal drugs, using the regulatory apparatus already in place to control the manufacture and sale of alcohol and tobacco; and
- government monopoly supply, with mandatory labelling of purity and strength, with no advertising or price promotions.

It is significant that this list does not include any attempt to cure the addicts of their addictive habits, although the medical concern is evident through the fear of the spread of HIV infection.

Harsher Penalties

If we were prepared to pay the direct and indirect costs associated with a tougher effort to enforce the prohibition, it would first result in higher prices on the black market. If dealers were incarcerated, the

higher returns would attract additional unscrupulous entrepreneurs into the networks. The higher penalties would provide a greater incentive for drug dealers to attempt to subvert the criminal-justice system, and the higher prices would provide them with the higher returns necessary to achieve this. The evidence from New York in the mid-1970s, when Governor Rockefeller instituted harsher penalties, is that the courts and prisons became overcrowded with drug offenders, and that there was a marked increase in the use of under-age youth by the distribution system, since the courts were more lenient towards them. Such an approach might provide the cynical politician with the appearance of success (in terms of more drug seizures and more people in prison), but the real test must be a reduction in the flow of the drug to the streets, and there is strong evidence that the Australian electorate would not accept the curtailment of civil liberties sufficient to achieve this goal using these means.

De Facto Decriminalisation

This is similar to the Dutch system for soft and hard drugs, in which the prohibition against personal use and possession is relaxed, while commercial growing, manufacture, refinement, imports, exports, and selling remain illegal. There is evidence that, despite the disquiet of its EC neighbours, the Dutch system has been successful. Would such a system provide an implicit signal to potential users that the government approved of the use of these drugs? Of course, there are already mixed signals with regard to the legal drugs of alcohol and tobacco: their advertising is severely restricted, and their purchase and consumption are also controlled. A more telling argument is that allowing discretionary powers in the enforcement of the law is just asking for corruption of those with the power to exercise discretion, as with gambling and prostitution in Queensland.

De Jure Decriminalisation

This avoids the temptations and pitfalls of the discretionary powers of the de facto decriminalisation, but it is more appropriate for cannabis, which can be consumed with a minimum of processing of the raw plant material, than it is for the opiates in general, and for heroin in particular. Nonetheless, several American States have decriminalised the use of marihuana, and it is interesting to note that the threatened flood of users has not eventuated, as figures quoted by the Cleeland Report (p.101) demonstrate. (This is confirmed by the South Australian experience of its expiation system for possession, cultivation, and private use of small amounts of cannabis by adults; see Sarre, 1989.) Given the altogether different qualities of the two drugs, it is doubtful whether extrapolation from this experience to what might happen with decriminalisation of opiates would be valid, although opium poppies will grow throughout temperate Australia, the Tasmanian opium farms being some of the world's most productive growers for pharmaceutical morphine.

Prescription Heroin

The medical model of drug use is one that has survived most strongly in the UK, where physicians retained the right to prescribe heroin and cocaine long after their professional colleagues had lost it in Australia and the US. Some have argued that it was an experiment that failed, but to close observers the British experience of clinics for registered drug addicts it was never an experiment but a continuous evolution of a way of dealing with a demand for drug use which was not dwindling, and which was not appropriate for legal controls alone. As others have argued, a system where heroin is only available to those who can demonstrate a prior addictive habit is one that provides a strong incentive to users not to remain occasional tasters.

Regulated markets, in which drugs were made available through government outlets, could ensure that drugs were clearly marked with their purity and strength, could preclude minors, could prohibit advertising, and could provide the government with some excise revenue.

Nonetheless, the medical approach of prescription drug supply is a better way of dealing with the problem than our present system, and is not very different from the methadone maintenance programs that are treating over 6000 drug users in Australia today. The most significant difference between heroin and methadone is that one is legally available and the other is absolutely prohibited. There are minor differences in other respects, such as the period to the onset of withdrawal, but a key contrast is that addicts evidently prefer heroin to methadone, and often supplement their legal intake of methadone with illicit, street heroin.

The outcome of the National Health and Medical Research Council trials of providing IVDUs with injectable drugs on prescription, to remove any need to

share needles (Foy et al. 1989) should answer the questions raised by Hawks (1988) and others about the practicality of the procedure.

Licensing

A system of licensing drug users, while providing society with the assurance that completely unrestricted access to drugs is prevented, at the same time removes the profit incentives of the black market. Under this proposal, over-the-counter drugs would be available at a low charge to licensed users, with some record kept of the extent of drug use for each user. To obtain a licence, one would have to follow a procedure similar to that for obtaining a firearms licence: be over 18 years old, have taken a course in drug education, and wait for a cooling-off period of some days before the licence was issued. Since the drugs in pharmaceutical form are of no threat to others, there is no reason — unlike a gun licence — why a criminal record would be a bar; indeed, preventing people who had a criminal record from becoming licensed drug users would be asking the black market to continue. If high-quality drugs were freely available, and if adults could relatively easily obtain drug-users' licences, then there would be virtually no demand for black-market drugs, certainly not enough to support their profitability.

The Cleeland Report puts the case for regulated supply very well. It attempts to balance the benefits of the existing prohibition in deterring new drug users and encouraging existing users to seek treatment, against its costs both to society and to the users themselves.

Commercial Supply

At a time when governments have been moving towards greater restrictions on the promotion of alcohol and tobacco, it is virtually impossible to imagine them opening up a commercial market for opiates in general, and heroin in particular, even if regulated to the extent that the supply of alcohol and tobacco is now (no under-age smoking or drinking, the products sold only from licensed premises, restrictions on advertising, restrictions on places of consumption — even if there are health reasons for some of these restrictions, and, importantly for taxpayers, high rates of excise levied on their sale). Perhaps there is some memory of the turn-of-the-century patent medicines, virtually all of which included opiates, and none of which in the absence of pure food laws provided information of their ingredients.

A Regulated Supply

Regulated markets, in which drugs were made available through government outlets, could ensure that drugs were clearly marked with their purity and strength, could preclude minors, could prohibit advertising, and could provide the government with some excise revenue. Under this scheme, the price might have to be very low initially, in order to undercut the black market. Such a scheme would require Australian withdrawal from our international obligations under the Single Convention on Narcotic Drugs, but as a sovereign state Australia can legally institute such a scheme, given the political will. The Americans, always at the vanguard of drug control, might be unhappy, but there is growing realisation in the US that their drug policy may be an unpopular export abroad. The most recent example of the US exporting its domestic policy is the 1989 UN convention against drug trafficking, which Australia has already signed. If we ratify the convention, with accompanying enabling legislation, it will be that much more difficult to acknowledge the failure of the punitive, supply-side campaign against heroin use and to liberalise the availability of the drug.

The Cleeland Report puts the case for regulated supply very well. It attempts to balance the benefits of the existing prohibition in deterring new drug users and encouraging existing users to seek treatment, against its costs both to society and to the users themselves. Against any increase in (regulated) drug use 'must be balanced the benefits which would flow from the elimination of the illicit market. Even if legal supplies were heavily taxed to act as a disincentive to widespread use, it would still be possible to undercut the illicit market, which would therefore die away. There would be savings in law-enforcement costs, in court time, and in the costs of imprisonment' (pp. 112-13). The proposal would reduce the subsidy to organised crime from all Australians, as reflected in our home insurance premiums, via the benighted heroin users.

The Report continues,

> At the same time, the proceeds derived from the taxes could be used to fund drug-education and rehabilitation programmes. The costs to the community of drug-related organised crime, corruption and property crime would be eliminated. Crime and corruption would, of course, not disappear, but they would no longer be fuelled by the need to

> purchase drugs at artificially inflated black-market prices. The illegal drugs would no longer have the glamour of forbidden fruit. Heroin users would no longer suffer the consequences of injecting drugs of uncertain strength and purity, and barriers to their seeking medical treatment would be removed. No longer pariahs to mainstream society, they would come forward more readily for medical treatment, and could be targeted for education on such issues as the risk of sharing needles in the age of AIDS. Cheaper heroin, in particular, could be expected to lead to a reduction in injection and a change to other methods of administration which pose fewer dangers to the health of the user. Informal social controls might develop which would operate as barriers to heavy use and addiction. (p.113)

(Examples of social controls over drinking that we take for granted are the disapproval that greets solitary drinking and drinking before lunch.)

Opponents of this view argue, for instance, that organised crime would move into other areas if denied the existing profitability of the heroin black markets. Of course, if such potentially profitable opportunities exist now with no barriers to entry, then there will be unscrupulous individuals or organisations seizing them already; otherwise, such actions will be very much second-best, with a lower rate of return. Indeed, on such an argument Prohibition should never have been repealed in the US — which overlooks the dynamic nature of the markets and the evidence that the longer the prohibition — of alcohol or opiates — continues, the wealthier, and hence more powerful, those who profit from the illicit trade become.

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A response to this article by Professor David Hawks, of the National Centre for Research into the Prevention of Drug Abuse, will be published in the Winter 1991 issue of ***Policy***. Policy