("starting life in a test-tube"). Evidently, Oregonians have been looking at opportunity costs. Medical costs vary widely from area to area, but a fair estimate would show that successful artificial insemination is not cheap and that in vitro fertilization costs some ten times as much as a normal conception and birth.

It is easy to empathize with an infertile couple who feel they must have a child at any cost, but community decisions are best made on the basis of opportunity costs to the community. If the majority of the people believe that the birthrate needs to be nudged upward, a given investment can produce more babies if funds assigned to subsidize births among infertile couples are diverted to pay for births among couples of proven fertility.

A new variation on the infertility theme has been recently introduced: creating artificial fertility among post-menopausal women. At considerable expense it is possible to implant a fertilized egg (from another woman) in the uterus of a 60-year-old woman, where it surprisingly thrives and develops normally. And one empathizes with the would-be mother. But again, there is the question of community interest. We have good evidence that extra costs (of several sorts) are imposed on the community when 13-year-old girls become mothers. Though it may be ungracious to say so, are there not reasons for expecting that 60-year-old mothers, as a class, will impose extra costs of a different sort on the community? Certainly their late-born children are more likely to become deprived of their mothers before they are old enough to vote.

A few years ago the economist Lester Thurow estimated that each new American baby requires an investment of some $240,000 to turn it into an average citizen-worker-consumer. (Grossly abnormal babies require a great deal more investment, and the end product is likely to be less competent to run life's race.) Considering all these facts, the mythical Man from Mars would no doubt think it odd that earthlings should view the production of children as a purely private matter, the prerogative solely of the fertile couple. In frontier days, when isolated couples took care of all the needs of their developing children, parenthood as an unqualified right made sense. But today, with every decade that passes, the larger community assumes more and more of the expenses of childrearing. An ancient maxim states that "he who pays the piper calls the tune." Will public policy on parenthood and public health care eventually be determined by this old saw?

Last, and most difficult to deal with under a would-be universal health care system, are the middle years of life. For the wealthy few who pay their own medical bills, there would seem to be no serious problems (though medical facilities are limited no matter who pays the bills). No person, no committee can yet draw up a detailed plan for a stable system of publicly financed health care. The final solution (if there is one) is unknowable.

The costs and benefits of publicly financed medical care during the middle years depend on many factors: the age of the recipient; the probable future earnings of the particular individual; the probable costs of future medical treatments; and the plausibility of further advances in medical science. Discrimination takes place along many logical axes, and the best weighting of the various factors will not be speedily agreed upon. Controversy will continue.

We would like to foresee all of the unintended bad consequences of social innovations, but this is impossible almost by definition: if we could accurately foresee them we would take evasive action. After thinking long and hard, we will just have to do the best we can with the available knowledge.

We may have more success in predicting the good consequences of a national health care system. Beyond the aggregate gain in public health, conflict over costs should help persuade the general public that we live in a world of real limits. Such a statement would be a mere truism were it not for a steady counterpressure exerted by entrepreneurs and advertisers in our highly commercial society. During the last two centuries the reality of limits has become a radical idea. We have been urged to "fly now, pay later!" Plastic money substitutes for paper money; spending is pushed harder than thrift.

Disputes over health care may push us over the threshold into a world in which limits become pervasive psychological realities once more. When shortages become obvious, individual discrimination—electing one alternative over another—is necessary if chaos is to be avoided. Discrimination by whole classes is both wasteful and cruel when the classes are races, as we learned a generation ago. But discrimination in the light of community need and individual merit is both efficient and just. Everyone likes to say "Yes!" but every explicit Yes implies No to a host of alternatives. A national health care system will be well justified if it reinstates discrimination as a proper function of the social order. c

Questions

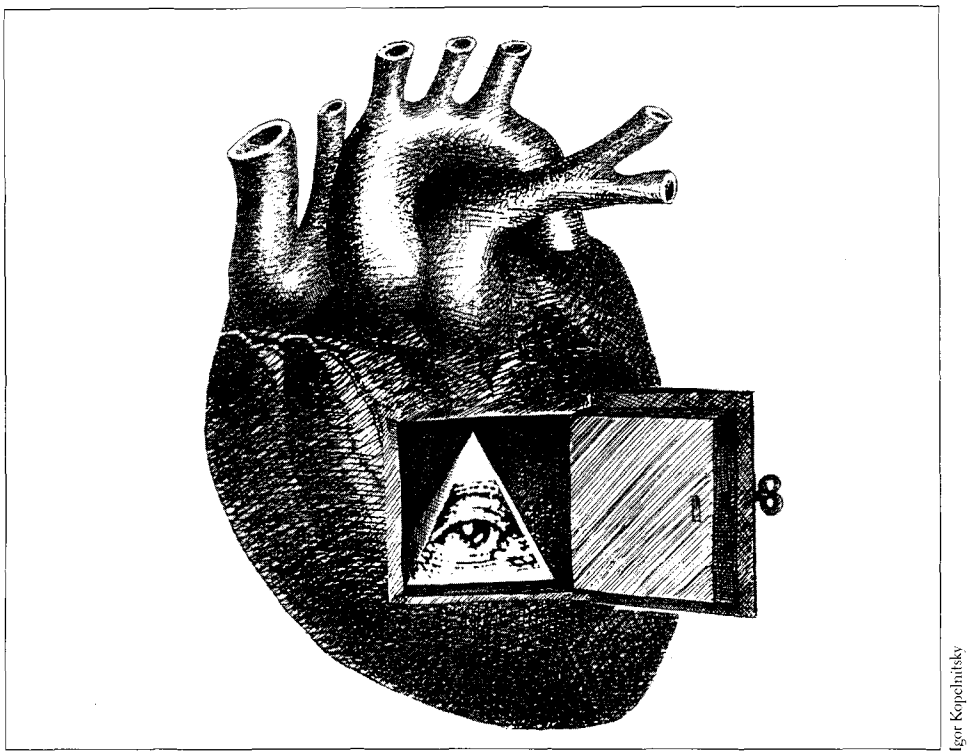
upon reading another long list of grant recipients

by Katherine McAlpine

Who are these writers whom nobody reads?
Why have I never heard most of their
names?
What's the criterion government heeds?
How are these writers whom nobody reads,
grinding out literature nobody needs,
finding success in the subsidy game?
Who *are* these writers whom nobody reads?
Why have I never heard most of their
names?

Medical Control, Medical Corruption

by Llewellyn H. Rockwell, Jr.



Igor Kopelnitsky

The vested interests are sick over it: Americans are beginning, just slightly, to take charge of their own health care. Such best-sellers as the *Doctor's Book of Home Remedies*, the *Physician's Desk Reference*, and the *Merck Manual* can keep you out of the doctor's appropriately named waiting room, or at least help you understand what is being done to you, when an apple a day does not work.

Who is unhappy with this increased knowledge? The American Medical Association, which for almost 150 years has sought to institutionalize a rip-off and to keep sick people and their families oblivious to it. Thanks to this central committee of the medical cartel, the number of medical schools and medical students is drastically restricted, state licensure further obstructs the supply of doctors, fees are largely secret and controlled across the industry, alternative treatments and practitioners are outlawed, pharmacists and nurses are hamstrung, and the mystique of the profession rivals the priesthood, although priests have a somewhat lower income. Meanwhile, the customer pays through the nose, even if he does not go to an otolaryngologist.

Medicaid and Medicare have contributed to the problem, but the medical cartel is the original sin. Through its ability to keep incomes high by limiting supply and outlawing competition, organized medicine has punished its customers, although the word is never used so as to disguise what is, after all, an economic relationship.

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Hillary Clinton's proposed merger of the medical cartel and the state seems like a radical move, and it is. It is also the logical next step in the partnership of government and medicine. That is why, in addition to opposing Hillary hammer and tongs, we should reexamine the AMA's distortion of the medical marketplace and the very idea of medical licensure.

Competition among providers—as with any service in a market economy—leads to rational pricing and maximum consumer choice. But this is exactly what the AMA has always sought to prevent. The American Medical Association, organized in New York in 1848, advanced two seemingly innocent propositions in its early days: that all doctors should have a "suitable education" and that a "uniform elevated standard of requirements for the degree of M.D. should be adopted by all medical schools in the U.S." These were part of the AMA's real program, which was openly discussed at its conventions and in the medical journals: to secure a government-enforced medical monopoly and high incomes for mainstream doctors.

Membership in the new organization was open only to "regular" physicians, whose therapies were based on the "best system of physiology and pathology, as taught in the best schools in Europe and America." The public had a different view, however. Official treatments of the time, such as bloodletting and mercury poisoning, harmed and sometimes murdered patients, causing mass outrage.

Emphatically not included among the "best" were the homeopaths. Homeopathy, a less invasive system that still thrives in Britain and Europe, may have done no good, but that was the worst charge lodged against it. Homeopathy did not kill people, as orthodox medicine did. The homeopaths actu-