salmon, Land ranches in Montana, and Scott, the youngest boy, is an animal psychologist in France, specializing in monkeys. Following the example of his own father and grandfather back in Minnesota, Charles Lindbergh let his children find their own way. Amusingly, Scott treats his monkeys in the family tradition, letting them go out from protected quarters "into the nature" ("*dans la nature*") as they please.

Brought up in an atmosphere in which individualism was encouraged, it is small wonder that Reeve, the youngest daughter, cannot possibly understand how biographers such as Kenneth Davis see her father as a "totalitarian" personality. When, as a girl in the benighted sixties, she voiced doubts about American democracy, Lindbergh—the alleged anti-democrat—argued "long and intensely" that her "starry-eyed" Leftish friends failed to appreciate the advantages of a "correctible democracy." He converted her, not vice versa.

Although he had always been a most private person, resenting the intrusive demands made by other Americans on his time and energy when he was a "public" figure, Lindbergh always had a secret love affair with his country. Even when he had to flee to England to protect his family, he knew he would be coming back. There were never "two Lindberghs," and in this year of the golden anniversary of a pioneering flight, it is time to put the old clichés to sleep for good. □

Harry Schwartz

Plop Plop, Fizz Fizz

What government should and shouldn't do about medical costs.

Even as I write these words, a titanic struggle is underway in Washington, D.C. The Federal Trade Commission is striving with might and main to protect me and you and you and you. The forces of evil against whose machinations the FTC is struggling so fiercely are those friendly folk who do so much to support television, the networks and the independent stations both. You know, the people who put announcers to such tasks as putting tablets in glasses of water and pronouncing poems of purest ecstasy over the fact that tablet A dissolves one-tenth of a second faster than tablet B. Yes, it's the over-the-counter drug industry, the good people whose cheap products save us so much money every year in avoiding visits to doctors and hospitals. The FTC is worried that one of these companies might want to advertise that its tablet or pill or lotion or cream or whatever might be good for the blahs or for the trots or for that horney feeling you get every once in a while. No such villainy will take place if the FTC has its way. Each over-the-counter remedy will have a few prim, standardly phrased claims authenticated on the label and that's all the advertisers are going to be able to talk about. What we do about the blahs, the trots, or that horney feeling will be our business. Such language isn't used on drug labels whose authors are all born-again Puritans. Of course the drug companies are complaining and fighting, and even as I write, hearings on these momentous issues are going on in Washington. The head reels to think of the millions of dollars being spent on lawyers' fees alone in these incredible proceedings.

I begin with this remarkable event because the chief topic of health conversation these days is no longer the grim toll taken by cancer and heart disease or something serious like that. When we talk about illnesses these days, we usually discuss either esoteric and exotic ailments like Legionnaires Disease or virtually non-existent diseases like swine flu. "Cost containment" is the magic phrase to mention early and often if you find yourself at a cocktail party or a massage parlor with a group of health apparatchiks. Health care costs too much and something's got to be done about it. (Of course, if you were dying of incurable cancer, you might think the something to be done would be a doubling or tripling of spending on research about your particular type of malignancy.) But the people who talk this way are usually very healthy, and besides they see chances for getting better jobs or bigger research grants as part of the push to cut health costs. A few are professional sadists and spoil sports or secret members of the Women's Christian Temperance Union or one of its fellow-traveler organizations who think the high cost of health care is the lever that will get the old 18th Amendment and glorious Prohibition reinstated. But anybody with a micron of intelligence knows that aspirin and Dristan and Rolaids and the kindly pharmacist who sells them are the most effective weapons we have to date against rocketing health care costs. Every pharmacist I've ever met is prepared to give you an instant diagnosis of your version of the blahs and to suggest one of his better profit margin non-prescription remedies to do what needs doing. And it usually works, I've noticed. And here are these FTC jokers trying to prevent all the pitchmen, even the pharmacist, from telling us what's good for the blahs. Hasn't anybody told them about the First Amendment?

Here in standard bureaucratic prose is the Carter Administration's description of the health care cost crisis as given in President Jimmy's budget revision statement last February:

"National health spending per person has more than tripled during the last decade, from $212 in 1966 to $638 in 1976. Total national health expenditures grew from $42.1 billion to $139.3 billion during the same period. The availability and use of new medical services account in part for rising spending. Nevertheless much of the increase has resulted from health cost inflation. Without cost restraints, Federal spending for Medicare and Medicaid alone would climb 75% between 1978 and 1982, from $38 billion to $66 billion."

Apparently something dreadful happened in 1966 which unleashed the inflationary monster. The solution would seem to be obvious: Find out what inflationary monster was let loose in 1966, get rid of it, and health spending per person would zoom down again—maybe not all the way to $212, but $300 ought to be

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attainable. And it's quite clear what happened in 1966. That was the year Medicaid and Medicare got off the ground, going from zero dollars spending to next fiscal year's budgeted $38 billion. Just abolish Medicaid and Medicare. The $38 billion saved that way would come to about half the projected Carter budget deficit in fiscal 1978. And imagine how doctors' fees and hospital room rates would crumble in consequence. Your friendly local GP might even call you up and ask if you wouldn't like a house call at a special rate—just for sociability, even if there's nothing detectably wrong with you. And that local general hospital which is collecting $200 a day from Blue Cross every time you go in to have your heartburn investigated might run a sale—you know, $25 a week in a private room for a honeymoon couple and nobody will ask you for your marriage license. There's nothing like a sharp decline in business, after all, to make people much more reasonable about price and delivery conditions.

But of course all that's an idle dream. Medicare and Medicaid aren't going to be repealed. How could I even think of such an awful idea? Do I want to deny the elderly and the poor the medical care they need? But people who ask such questions don't realize I'm such an old duffer that I can remember what it was like before Medicare and Medicaid. We were poor when I was a kid but that didn't mean we didn't get medical care. We always went to the nearby hospital clinic where the standard fee was 50 cents. And if occasionally we called a private doctor, he not only came but apologized for asking for a $2 fee. My maternal grandmother —may God rest her soul—got such good medical care in this country on practically zero income that she died at age 92 well before Medicare.

No, Medicare and Medicaid are safe. There's so much free floating guilt around—after all, wouldn't you feel guilty if you were Joe Califano and made the amount of money he did last year?—that Medicare and Medicaid will not only continue, but will be expanded. In that very same Carter budget message quoted above, it was announced that Medicaid would be expanded still further by setting up a new screening program that will expose 14 million kids—not just 12 million as at present—to the risk of becoming hypochondriacs by sending them to doctors and nurses when they don't feel any pain at all. And to secure that goal, the bribe to the states for participating is being upped to 75 percent of the bill. Some way to save money!

No, the way we save money on health costs these days—and on this there really is no difference between the Nixon, Ford, and Carter Administrations—is by means of price controls and policemen. Carter has already announced a "cap" on hospital costs which have been going up 15 percent a year, but are henceforth to be permitted to go up no more than 10 percent a year. And what happens if the cost of living goes up more than 10 percent a year? That awful possibility and its implications for hospital costs don't seem to have occurred to the would-be regulators. Anybody remember when Jimmy Carter ran against Washington and all those dreadful regulators and regulations that made life impossible for ordinary folks like us?

The doctors needn't be so cocky. Their turn will come. First the screws are applied to the hospitals, and then, that task finished, out will come the national fee schedule or whatever the Carter Administration will choose to call it. But nobody should have any illusions. When that fee schedule goes in, the doctor will give you your 30 seconds, no more and no less. If you expect him to be interested in your troubles and really do something about them—you'd better figure out a way to slip him a supplement the way wise people do in Moscow and Prague. And, of course, if we go far enough down that road, we'll have two medical systems just as in the Soviet Union—one for the proles, the majority, and the other for the ruling minority.

But price and wage controls in medicine—for that is what the Carter Administration has in mind, whatever the terminology it employs—won't do the trick. The ultimate aim of the present Washington policymakers, after all, is National Health Insurance. And that goodie, the ordinary guy and gal think, means that everybody gets all the health care he or she wants whenever they want it. Nonsense!

Powell's Law stands there glowering all the time. For those who've forgotten, Powell's Law is the piece of common sense which points out that there is an infinite demand for "free" health care—or at least for health care paid for by somebody other than the beneficiary. There is always another doctor who can be called in, another treatment that can be tried, another amenity that can be installed to ease the lot of the afflicted one. And why not try them all if it's "free"? Dr. Kevin Cahill, Democratic Governor Hugh Carey's health dictator for New York State, told me some time ago that New York is forking out about $35,000 a year to care for every one of the retarded patients at infamous Willowbrook—but even that is not enough, as every new exposé of the conditions at Willowbrook reveals.

The point is that as health care becomes more and more "free," whether because of Medicare and Medicaid, or because of national health insurance, or because you've been enrolled in a Health Maintenance Organization, it has to be rationed somehow. Already the first instruments of medical rationing are in place and beginning to operate. Have you ever heard of a Professional Standards Review Organization (PSRO to the cognoscenti)? Practically every hospital belongs to one, and it's the job of the PSRO nurse to see that you get thrown out of the hospital as soon as possible—at least if the government or an insurance company or a Health Maintenance Organization is paying your hospital bill. Of course, if you're paying your own hospital bill, you can stay as long as you want to. But who can afford to pay current hospital bills at the rates to which they've been driven by insatiable demand born of Blue Cross and other third-party-payer inspired inflation?

But, as the British discovered long ago, the best means to ration medical care—by making you wait for it, wait perhaps until you die —is by making resources unavailable. The hospital that isn't built can't be used for patients. The surgeon who isn't trained can't operate. The method is simplicity itself. But here in the United States we've been on a jag building hospitals, training doctors, buying equipment, etc. Have you any idea how many hospitals have been built with Uncle Sam's help through the almost unknown Hill-Burton legislation, or how many additional doctors have been trained through government subsidies to medical schools?

All that was in the bad old days. Now we're creating Health Systems Agencies—and bow low when you pronounce the magic letters HSA—and they're going to plan the medical system of each part of the United States. For a starter they're going to focus on hospitals and the like, but down the road one can see these eager

planners deciding how many dermatologists Flatbush or Marin County is entitled to and where they may have their offices. All this, of course, is under the flag of avoiding waste and needless duplication. But the HSA's waste may be that hospital around the corner you've been accustomed to going to. You won't like it when they close that hospital down and you have to go to another one 20 blocks or 20 miles away, depending on where you live.

Moreover it's important to cut out fraud, and even the village simpleton knows by now that the freer medical care has become in this country, the more crooks have supped at the Federal treasury's trough. So more and more we'll have policemen overseeing the medical system, policemen working for HEW's new Inspector General or his local counterparts in state and municipal and county governments. Did that 90-year-old lady really need to be in a nursing home? After all she does have an apartment on the top floor of a five-story walkup tenement. Should Jim Smith really have had that hernia operation? His truss didn't seem to be inconveniencing him any. And so it will go as the policemen dig in.

What it all adds up to is that government is behaving in its usual Janus-faced fashion. One face is promising us new wonders of free medical care, with the hint that even immortality may be down there at the end of the road as the result of some marvellous discovery by the National Institutes of Health scientists. The other face is perpetually frozen in a snarl born of ceaseless complaining that it costs too much. Who's to blame? That's easy. In the official demonology, it's the inefficient hospital managers and the greedy doctors. Just take care of them, and all will be well. The notion that the troubles begin with "free" medicine in the first place because the consumer has no motive to economize must of course be rejected out of hand. Ye gods, such subversive reasoning might even lead one to blame Congress and the President, who are taking the bows for today's free medicine and looking forward to taking the bows for tomorrow's free medicine.

So the future looks good for medical bureaucrats, for medical inspectors, for medical policemen, for medical computer specialists—in short, for the whole army of paper pushers that a vast and complex government organization accumulates automatically. For sick people and those who try to take care of them things don't look so good.

What is tragic is that there is a mechanism for combining humanitarianism with a healthy respect for medical economy. It can be built on a simple principle: The important thing is to help people who really need help. Another name for this mechanism is catastrophic health insurance.

The basic fact is that most Americans are healthy most of the time. The average American family can afford to pay out of pocket normal medical expenses. There is no need to set up a monstrous "free" medical system without any incentive for patient economy. The real problem is that posed for people who have severe illness for which something can be done. Leukemia was cheap 30 years ago when nothing could be done and the patient died more or less promptly. Leukemia is financially expensive today *because* for many forms of the disease patients can be kept alive and even functioning fairly normally—often for many years after the disease strikes. Kidney disease killed fast in the old days. Now kidney dialysis keeps patients alive and functioning for years and kidney transplants—in thousands of cases already—have made patients almost as good as new. A heart attack that would have been fatal a decade ago you may now recover from and go back to work—but only after spending a month in the coronary intensive care unit where the cost may exceed $500 a day.

What this suggests therefore is that the proper role of government in health care financing is just one: To encourage as many people as possible to get catastrophic insurance, meaning insurance that will compensate them for medical costs that go above some significant percentage—15 or 20 percent say—of a family's income. This should be done regardless of age—90-year-old Cyrus Eaton doesn't need Medicare—and the use of a percentage of income as the cut-off point means that expenditures which would be considered normal for a family from Great Neck or Newport Beach would be considered catastrophic for a family living in Bedford-Stuyvesant or Watts or Appalachia. But in all these cases the patients would begin with some incentive to economy because they would have to pay the first dollars of medical care. (To my mind, first-dollar medical or hospital insurance of any kind ought to be outlawed—with a very stiff penalty for violation.) But of course this scheme can be abused, too, After a family has passed the threshold percentage of its income, the care it receives is "free" and the door is wide open for all the old abuses. There has to be a watchdog, something some people would call the Death Committee while the Nice Nellies would call it the Optimum Medical Use of Resources Committee. In each case the point is the same: The committee would have the job of deciding when enough is enough. The Karen Quinlans of the world would not be allowed to remain under care, unconscious, living their vegetable existences without hope, forever.

And oh yes, we would let Rolaids, Dristan, et al. claim they combat the blahs. Maybe they do. More important they don't cost very much. Most conditions you take them for go away of their own accord. And if you didn't take those non-prescription drugs, you'd probably visit your doctor and start chipping away toward the point at which catastrophic medical insurance would take over.

None of this is new. The ideas have been around for years. But there are no votes to be garnered by promising people you'll pay their medical bills only if they suffer a catastrophe. Many voters, unfortunately, and even more the demagogues who crowd the electoral lists each year, prefer to think that even one dollar paid by the patient for medical care is a disaster. Little do they know! □

Ernest van den Haag

Preventing Crime with Punishment

The credible threat of punishment remains the most effective deterrent to crime.

The fundamental purpose of criminal laws is to use the threat of punishment in order to restrain persons who are tempted to do what the laws prohibit. Thus, Timothy I (1:9): "The law is not made for the righteous man, but for the lawless and disobedient."

And who is likely to be "lawless and disobedient"? Some persons are tempted to commit crimes for individual and intrapsychic reasons; others because nature or society placed them in a disadvantageous position which reduces their legitimate opportunities and, in comparative terms, increases the attractiveness of illegimate opportunities. The law is addressed to all those impelled toward crime, whatever their temptation; it would be redundant if addressed only to those not tempted to do what it prohibits. The greatest burden of the law thus is on those most tempted to violate it, usually those with the fewest legitimate opportunities and satisfactions. Rich adolescents, for example, are less tempted to steal cars, and will commit fewer car thefts than poor ones. There is no way—under capitalism, socialism, or any social system—of equalizing temptations, or individual needs, or individual responsiveness to them. Hence the law will always be more burdensome to some than to others. It is in the nature of any prohibition to affect different people differently, and to be most painful to those most tempted to do what is prohibited: they will have the greatest difficulty obeying. They will also be punished more often. To prohibit rape or theft imposes a heavier burden on one tempted to commit either offense than on a person not so tempted, whether by his circumstances or by his character.

Roughly speaking, the burden of the law will always be heaviest on those placed in the least advantageous position by nature or society—the poor or those brought up in an unfavorable family environment, e.g., by violent or cruel parents. Yet contrary to what one so often hears, it is still mainly the disadvantaged—the poor and the powerless—that the criminal law protects. In any society the rich and powerful can protect themselves. They need the law least. But the law is the only protection the poor and powerless have. They need protection against others, usually poor and powerless, as well, for most crimes are committed by the poor against the poor.

The threat of punishment can deter people from prohibited acts only if credible. Else the threat becomes ineffective. And the threat remains credible only if carried out as threatened. Obviously, the threat has been ineffective with those who have already violated the law; but threats of punishment will be effective enough, if properly applied, to restrain others from crime. Threats cannot and will not restrain everybody all the time, but they are effective in all existing societies with most people most of the time—provided they are carried out when the law is violated. Else crime pays and more crime will be committed as people realize that it does.

The threat of punishment is a purely utilitarian measure. It is meant to protect society. But we also try to be just when we carry out the threat. Thus we distribute the threatened penalties only to those found guilty of crime. Further, the punishment must be as threatened, i.e., not arbitrary; and it must be proportioned to the felt gravity of the crime.

In addition to threatening punishment we can also reduce crime rates by decreasing criminal opportunities, and by increasing legitimate ones. A better social order, it is contended, may reduce the temptation to, or pressure for, committing crimes. I have no doubt that changes in social arrangements—e.g., making divorce or employment easier to get—may have some marginal effect. And I favor some such changes. But their effect has been minor, and to stress them is to misplace the emphasis.

In this country an income of $5,500 for a family of four has been decreed as the poverty line. In 1900 ninety percent of all families were below the equivalent in actual purchasing power; by 1920 the figure was 50 percent; and in 1976, 11-13 percent. If the crime rate has declined similarly, it is a well kept secret. Education, psychiatric care, etc. also have been improved, and opportunity is far more equal than it ever was. Yet these changes have not reduced the crime rate. On the contrary: the crime rate among females and blacks has increased as their opportunities have become more equal. The reason for this seeming paradox is simple enough. Social conditions were improved. But the level of effective (credible) threats against criminal behavior was independently reduced. Only if that level is maintained can social improvements reduce the crime rate. And in the present situation the most urgent task is to increase the threat level. Punishment must become more certain and less lenient if the crime rate is to be reduced. At present it is still rising.

Incapacitation for habitual offenders might reduce the crime rate by reducing the offenses of those irrationally *addicted* to crime who, when free, commit crimes regardless of legal threats. (I mean addicted to crime, not addicted to drugs. Although many offenders are drug addicts, in most cases they were offenders before becoming addicts and the drug addiction contributes to rather than causes their crimes.) As long as they are incapacitated, these persons would not be able to commit the crimes from which they cannot otherwise be deterred. This would reduce the rate, say, of child molesting or of certain violent crimes committed in part for thrill and not for instrumental reasons alone. I should favor more incapacitation when possible—if and when we are able to tell the habitual law violator from others. But the practical possibilities are limited.

Unlike incapacitation, rehabilitation is not a practical possibility at all, and I doubt that it can ever be on a major scale. Let me quote a former president of the American Society of Criminology, Bruno Cormier (*The Watcher and the Watched*, p. 268): "Society must learn to accept that a delinquent treated by psychotherapeutic techniques may have benefited from such treatment even though he returns to crime." I am willing to accept that, but unlike Dr. Cormier, I do not think we should send people to prison for their health. Prisons are meant to protect society from crime—present and future—and, if convicts while benefiting from treatment still return to crime, I do not think the treatment was socially useful.

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