

A Way Out of Soviet-Style Health Care

Solzhenitsyn's prophetic warning about the depersonalization of medicine.

By [MILTON FRIEDMAN](#)

Editor's note: The following is excerpted from an article with the same headline by Nobel Prize winning economist Milton Friedman that was published in the Wall Street Journal on April 17, 1996. Friedman died in 2006. [A related editorial](#) appears nearby:

In a chapter in his novel "The Cancer Ward" titled "The Old Doctor," Alexander Solzhenitsyn compares "private medical practice" with "universal, free, public health service" through the words of an elderly physician whose practice predated 1918. . .

Mr. Solzhenitsyn himself had no personal experience on which to base his account and yet, in what I have long regarded as a striking example of creative imagination, his character presents an accurate and moving vision. The essence of that vision is the consensual relation between the patient and the physician. The patient was free to choose his physician, and the physician free to accept or reject the patient.

In Mr. Solzhenitsyn's words, "among all these persecutions [of the old doctor] the most persistent and stringent had been directed against the fact that Doctor Oreschenkov clung stubbornly to his right to conduct a private medical practice, although this was forbidden."

In the words of Dr. Oreschenkov in conversation with Lyudmila Afanasyevna, a longtime patient and herself a physician in the cancer ward: "In general, the family doctor is the most comforting figure in our lives. But he has been cut down and foreshortened. . . . Sometimes it's easier to find a wife than to find a doctor nowadays who is prepared to give you as much time as you need and understands you completely, all of you."

Lyudmila Afanasyevna: "All right, but how many of these family doctors would be needed? They just can't be fitted into our system of universal, free, public health services."

Dr. Oreschenkov: "Universal and public—yes, they could. Free, no."

Lyudmila Afanasyevna: "But the fact that it is free is our greatest achievement."

Dr. Oreschenkov: "Is it such a great achievement? What do you mean by 'free'? The doctors don't work without pay. It's just that the patient doesn't pay them, they're paid out of the public budget. The public budget comes from these same patients. Treatment isn't free, it's just depersonalized. If the cost of it were left with the patient, he'd turn the ten rubles over and over in his hands. But when he really needed help he'd come to the doctor five times over. . . ."

"Is it better the way it is now? You'd pay anything for careful and sympathetic attention from the doctor, but everywhere there's a schedule, a quota the doctors have to meet; next! . . . And what do patients come for? For a certificate to be absent from work, for sick leave, for certification for invalids' pensions: and the doctor's job is to catch the frauds. Doctor and patient as enemies—is that medicine?"

"Depersonalized," "doctor and patient as enemies"—those are the key phrases in the growing body of complaints about health maintenance organizations and other forms of managed care. In many managed care situations, the patient no longer regards the physician who serves him as "his" or "her" physician responsible primarily to the patient; and the physician no longer regards himself as primarily responsible to the patient. His first responsibility is to the managed care entity that hires him. He is not engaged in the kind of private medical practice that Dr. Oreschenkov valued so highly.

For the first 30 years of my life, until World War II, that kind of practice was the norm. Individuals were responsible for their own medical care. They could pay for it out-of-pocket or they could buy insurance. "Sliding scale" fees plus professional ethics assured that the poor got care. On entry to a hospital, the first question was "What's wrong?" not "What is your insurance?" It may be that some firms provided health care as a benefit to their workers, but if so it was the exception not the rule.

The first major change in those arrangements was a byproduct of wage and price controls during World War II. Employers, pressed to find more workers under wartime boom conditions but forbidden to offer higher money wages, started adding benefits in kind to the money wage. Employer-provided medical care proved particularly popular. As something new, it was not covered by existing tax regulations, so employers treated it as exempt from withholding tax.

It took a few years before the Internal Revenue Service got around to issuing regulations requiring the cost of employer-provided medical care to be included in taxable wages. That aroused a howl of protest from employees who had come to take tax exemption for granted, and Congress responded by exempting employer-provided medical care from both the personal and the corporate income tax.

Because private expenditures on health care are not exempt from income tax, almost all employees now receive health care coverage from their employers, leading to problems of portability, third party payment and rising costs that have become increasingly serious. Of course, the cost of medical care comes out of wages, but out of before-tax rather than after-tax wages, so that the employee receives what he or she regards as a higher real wage for the same cost to the employer.

A second major change was the enactment of Medicare and Medicaid in 1965. These added another large slice of the population to those for whom medical care, though not completely "free," thanks to deductibles and co-payments, was mostly paid by a third party, providing little incentive to economize on medical care. The resulting dramatic rise in expenditures on medical care led to the imposition of controls on both patients and suppliers of medical care in a futile attempt to hold down costs, further undermining the kind of private practice that Dr. Oreschenkov "cherished most in his work."

The best way to restore freedom of choice to both patient and physician and to control costs would be to eliminate the tax exemption of employer-provided medical care. However, that is

clearly not feasible politically. **The best alternative available is to extend the tax exemption to all expenditures on medical care, whether made by the patient directly or by employers, to establish a level playing field, in terms of the currently popular cliché.**

Many individuals would then find it attractive to negotiate with their employer for a higher cash wage in place of employer-financed medical care. With part or all of the higher cash wage, they could purchase an insurance policy with a very high deductible, i.e., a policy for medical catastrophes, which would be decidedly cheaper than the low-deductible policy their employer had been providing to them, and deposit all or part of the difference in a special "medical savings account" that could be drawn on only for medical purposes. Any amounts unused in a particular year could be allowed to accumulate without being subject to tax, or could be withdrawn with a tax penalty or for special purposes, as with current Individual Retirement Accounts—in effect, a medical IRA. Many employers would find it attractive to offer such an arrangement to their employees as an option. . . .