

EIR Science & Technology

High technology makes health care cheaper!

The first in a two-part series by Wolfgang Lillge, M.D., on the "cost effectiveness" of high-quality medical care.

The congressional Office of Technology Assessment argues, in recent studies quoted in the accompanying box, that "the increase in the use of new and existing medical technologies" is responsible for the increase in medical costs. The OTA is the voice of the environmentalist, anti-nuclear, anti-defense lobby in Washington. Its "experts" are avowedly Malthusian: Their "objective study" of what they claim to be the runaway cost of medical treatment, is a thinly disguised justification for a policy of euthanasia as a method of population control.

The OTA's argument is hideously simple. High-technology medical treatment has extended life expectancy; this, says the euthanasia lobby, is undesirable. Beneath their fallacious cover-story that high-quality medical care is too costly, lies their hidden assumption: Merely allowing the elderly to stay alive is too costly. We present here the first installment of a two-part report, which is intended to expose this Nazi lie. We will also investigate the enormous promise of modern medicine, even in the abysmal situation confronting physicians and researchers today, in which basic research is hugely underfunded.

Technological progress is the necessary foundation of any healthy economy. Without investment in new technology, not only does an economy stagnate, but it becomes unable to maintain its future survivability as the existing resource base is depleted. It is necessary for a viable economy to increase its potential for future increases in productivity. The same basic economic principle is true for health care. Every efficient new technology introduced into medical diagnostics and treatment will cheapen the overall costs in the long run.

Today it is necessary to invest heavily in providing rising levels of health care for the world's population, if we are not to experience a repeat of the plagues of the Dark Ages, and an accelerating downward spiral of diseases and uncontroll-

able epidemics. AIDs is only one case in point.

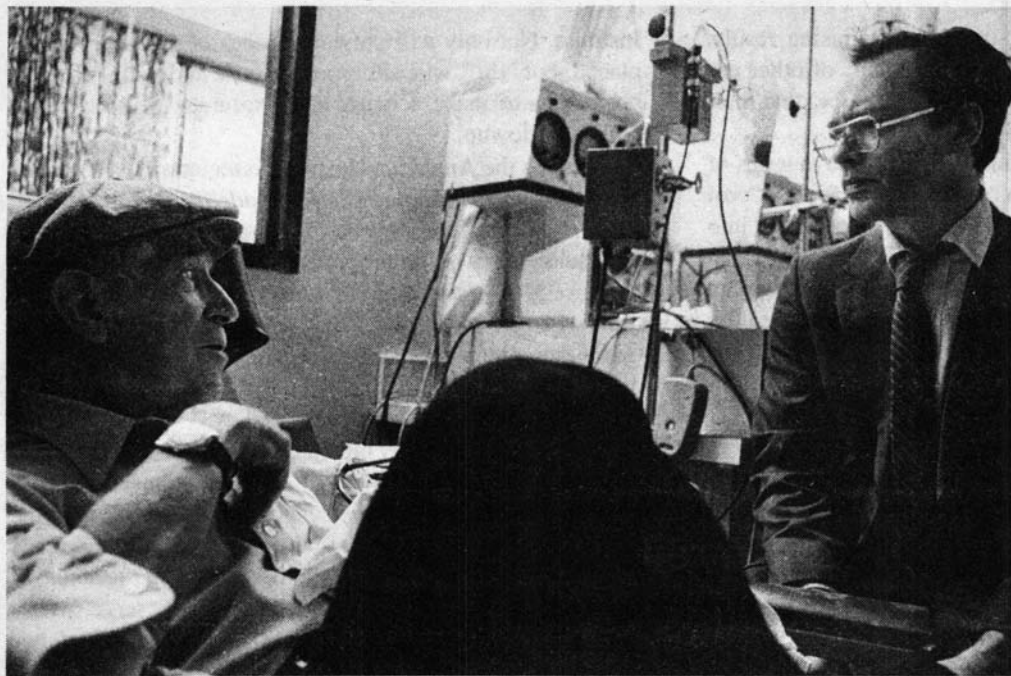
The logical consequence of the ideology of cost reduction in health care is euthanasia. At a certain point, the life of a human being becomes cheap, and individuals will fall under

OTA demands an end to 'costly' medical research

The following is an excerpt from the Office of Technology Assessment's 1983 report, "Diagnosis Related Groups and the Medicare Program: Implications for Medical Technology":

The increase in the cost of hospital care has been a persistent and growing problem for both the Medicare program and the general public for more than 15 years. A substantial portion of the increase in hospital costs has been attributed to an increase in the use of new and existing medical technologies. . . .

There are two general incentives inherent in any per-case payment system: 1) to reduce the cost to the hospital of each inpatient case stay, and 2) to increase the number of inpatient admissions. Cost per case can be reduced by using fewer technological services, including ancillary services, reducing the number of inpatient days, or both.



The Office of Technology Assessment of the U.S. Congress maintains that one of the "constraints" which makes cost-cutting difficult, is the fact that physicians have "financial, ethical, and legal reasons to practice high-quality medicine." Here, a doctor visits with a renal dialysis patient in a New York City hospital.

NSIPS/Carlos de Hoyos

the category of "useless eaters." Especially the elderly are considered to be only a financial burden for the health budget. Movements proposing "death with dignity," "living wills," etc., are the lobby for a euthanasia program which will decide

who shall live and who shall die, according to cost/benefit considerations.

In any instance, where research and high technology in health care have been combined to save the life of patients

This incentive may result in specialization among hospitals for services that require a minimum number of patients to maintain profitability. This specialization may imply lower access to care for some Medicare patients. There are built-in constraints of unknown magnitude on the possibility of adverse effects on access and quality. One constraint is the fact that physicians are the decision makers, and they continue to have financial, ethical, and legal reasons to practice high-quality medicine.

The following OTA report, "Medicare's Prospective Payment System, Strategies for Evaluating Cost, Quality, and Medical Technology," was released in 1985:

Twenty years ago, Congress made a major commitment to securing older Americans' access to acute medical care with the creation of Medicare. Subsequent legislation extended the Medicare program to disabled people and to victims of end-state renal disease. Medicare has been an unquestioned success in reducing financial barriers to health care for its beneficiaries, but the program's costs have risen rapidly.

Medicare's payment methods have discouraged doctors, hospital managers, and patients from making cost-effective decisions regarding the use of medical technology. Retrospective cost-based hospital reimbursement was

particularly troublesome and, most would agree, inflationary.

Congress ended cost-based reimbursement for inpatient hospital care for Medicare beneficiaries with the creation of Medicare's prospective payment system (PPS) in 1983. The new hospital payment system has reversed the financial incentives away from the provision of more care for hospitalized patients to the provision of less care.

Although the OTA claims that it does not issue policy statements, and pretends to an objective standard, the following, issued in September 1984, makes clear its position on reversing the trend toward high-technology medical care ("Health Technology Case Study 27: Nuclear Magnetic Resonance Imaging Technology, a Clinical, Industrial, and Policy Analysis"):

Although State certificate-of-need (CON) programs were never specifically intended to constrain the diffusion of medical technology, they constitute one of the major policy mechanisms available to health planners for control over technology adoption. CON review of "need" may be based on numerous factors, including clinical use of technology, institutional characteristics, economic and financial effects, and population-based considerations [emphasis added].