

clinical condition that is irreversible. This is especially true for cancer, where in most cases total cure can only be achieved when the malignant process is eliminated right at its onset. The only society which would not find this advantageous, is the fascist state—the dying society in which life is expendable and no productive future exists for the population.

While vaccination is the most effective method of disease prevention, known as primary prevention, screening programs function as secondary methods of prevention. Effective screening has two principal preconditions: First, the disease itself must be detectable at an early stage; and second, technologies and techniques have cheap and efficient, to detect this early stage of the disease. There are a number of such techniques available which have been established as highly effective—both in terms of their cost and their ability to detect disease.

It is clear that the ability to detect a disease in an early stage depends on our scientific knowledge about pathologic processes and on the development of diagnostic techniques. We will now look at some of these capabilities and analyse the question of why mass screening programs are not in as widespread use today as they should be. We begin with the cancer screening programs.

Cervical cancer: Screening for this type of cancer with the Pap test is perhaps the most powerful life-saver in the whole arsenal against cancer. An estimated 20-25 million American women take the Pap test each year, at an average cost of \$5 per test. The Pap test detects cancerous or precancerous cells taken from the cervix, and allows a reliable staging of several cell forms which indicate a later tendency to develop into a cancer.

About 5-10 cases of different pre-stages of the disease

How the bureaucrats are sabotaging health care

The congressional Office of Technology Assessment (OTA), since its creation in 1972, has played a leading role in sabotaging the implementation of advanced medical technology, on grounds that it is not “cost-effective.” One principal way in which such criteria are introduced is through the so-called Certificate-of-Need (CON) programs, operated by the different states through a jungle of anti-science bureaucracies.

The OTA’s main function, according to its own description, is “to help legislative policymakers anticipate and plan for the consequences of technological changes and to examine the many ways, expected and unexpected, in which technology affects people’s lives.” This type of “value-free” characterization about “concerns for quality of life” is the code phrase behind which “green” anti-technology fanatics are allowed to plot their strategies against progress. These are the same forces who think it would be better to eliminate the last year in the life of every citizen, because statistics show that that year has the highest health-care costs.

The OTA has set out to apply cost/benefit approaches to any emerging new technology. They publish detailed technology assessment reports whose only purpose is to discourage industry from investing in the development of new technologies, and users from purchasing them, by inflating their costs and under-counting their benefits.

According to CON regulations, any device which exceeds a cost of \$250,000 becomes automatically subject to review. That means, if a hospital or private practice

plans to purchase a Nuclear Magnetic Resonance (NMR) machine, for example, it has to make an application to the CON board and establish conclusive evidence of “need” for such an investment. The definition of “need” involves diverse criteria which are subject to arbitrary interpretation: consistency of the proposed project with state health plans, consistency of the project with the institutional applicant’s long-range plan, systemwide effects, financial feasibility of the project, access to care, quality of care, availability of services and personnel, construction and architectural considerations, effects on competition, competence, and character of institutional management, and selection of the best alternative means of providing the proposed service.

The CON procedure comes on top of the intricate “premarket approval process” from the Food and Drug Administration, and this FDA procedure alone is well suited to derail or massively delay and raise the costs of even the safest and most efficient technological development.

If such a technology has managed to sneak through the FDA brushwood, its next hurdle is the CON approval process. And if it jumps over that, one can still not be sure that the various third party payers like Blue Cross/Blue Shield, HCFA, private insurers, etc., will include it in their reimbursement policy. A whole new set of review procedures is set into motion.

Here is the OTA’s own favorable description of the certificate-of-need programs:

“A major public policy response to the perceived problem of technology-induced cost inflation has been to attempt restraint of technology diffusion to hospitals. The prime policy instruments have been State certificate-of-need programs. . . . *Although CON programs were not*

are discovered in every 1,000 women examined, and in certain high-risk population groups—such as women between the ages of 30 and 40—the rate may reach 20 cases per thousand.

When cervical cancer is discovered early, cure rates are higher than 90%, and the cost of early surgery varies from less than \$600 to about \$1,200. In later stages of the disease, ultimate costs may run as high as \$50,000.

Dr. W. Ross, Jr. of the U.S. Public Health Service has offered a cost/benefit analysis of the Pap cancer test, which was presented at a conference of the American Cancer Society in 1979, which is still basically valid today. Over a five-year period, he estimated that it would cost \$68 million to bring the Pap test to as many American women as possible through grants to hospitals, clinics, health agencies, and public education programs. At the same time, it would cost \$50.6

originally intended to constrain the diffusion of medical technology, they have been used for that purpose. To the extent that individual devices had price tags exceeding the established dollar threshold for CON review, new medical technologies became subject to CON regulations. . . . CON agencies frequently play pivotal roles in determining which institutions may acquire new technologies [Health Technology Case Study 27 on NMR imaging technology, September 1984; emphasis added].”

This language barely conceals the liberal, environmentalist wrath against that technological progress which alone can lead the way out of economic stagnation. The incompetence of OTA's and CON's approach to the problem is so undeniable that the same OTA study had to admit:

“The inability of the [CON] planners to evaluate the technology [x-ray CT scanner] constrained its diffusion into medical practice more severely than may have been wise. The lack of available evaluative mechanisms and criteria for review made it difficult for planners to dispel the uncertainty surrounding x-ray CT scanning, thereby leading to many controversial and, at times, seemingly arbitrary decisions on individual CON applications. The net effect was a loss of credibility by the planners, as evidence of the truly revolutionary nature of x-ray CT scanning accumulated over time [emphasis added].”

Why, one has to ask, do we afford the luxury to maintain agencies which are not only useless, but also dangerous, as they admit themselves to be? Decisions on such vital questions as the competent use of high technology in health care must be trusted to people who want to preserve life, unlike our liberal pro-euthanasia congressmen who would even have outlawed the introduction of disinfectants, in order to protect the “civil rights” of bacteria and viruses.

million to treat all the newly discovered cases of cervical cancer, bringing total costs of screening and treating to \$118.6 million.

But the benefits, according to Ross, would exceed the costs ninefold: \$998 million saved over the five-year period in earnings by women whose early cure enabled them to return to work, plus \$73 million in expensive treatment costs averted. Thus the total program's benefit would be nearly \$1.1 billion!

As a matter of policy, the bureaucrats of the Office of Technology Assessment (OTA) come to quite a different conclusion. They stated, in a case study about the cost effectiveness of cervical cancer screening: “The results of the analysis show that the costs of screening for cervical cancer are always more than the financial savings of prevented future disease, indicating that private insurers have no direct financial incentive to screen.” Obviously they are giving a cost/benefit analysis according to the criteria appropriate to the insurer rather than the patient, or society as a whole.

This is not a naive error. It reflects not only a difference in analytical method: The OTA is adhering to a worldview that axiomatically does not allow decent health care for everybody. In the fantasy-land of systems analysis, every dollar spent for health care is a lost dollar.

A different way of analysing the situation is presented by Dr. Bernhard L. Cohen, in an article in *Fusion* magazine (March-April 1985) addressing the need for spending money for disease prevention directly, rather than trying to figure out what could be saved. This emphasizes the need to develop technologies with increasing effectiveness, i.e., to cover the cost to save a human life. He comes to the conclusion that in the context of a comprehensive cervical cancer screening program, you have to spend \$25,000 to save one life, which is relatively little compared to other screening programs available. Cohen writes that this is not “a study of the value of a human life, which is a moral, philosophical, ethical, and religious question. Rather, it is a matter of collecting observations and performing mathematical transformations on them, which is a straightforward application of scientific techniques.”

Breast cancer: Treatment of breast cancer in recent years has developed to a point where this disease can be considered curable, when detected at an early stage. Approximately 85-90% of cases from this category have a survival rate higher than the five-year period which is usually considered equivalent to total remission for cancer. Screening programs include palpation of lumps by the physician and/or mammography with a high degree of sensitivity. According to Cohen, society has to spend \$80,000 in screening costs for breast cancer to save one life.

Lung cancer: This is the cancer with the highest incidence rate, which has become the most frequent cancer in men and, at current growth rates, will soon be the most frequent in women. Screening programs so far have relied