evidence-based guidelines and cutting down on inappropriate care." In addition, the Board would "align incentives with high-quality care," an obfuscatory term which means paying doctors to keep costs down, and withholding payments for unapproved (read: "expensive") procedures.

Daschle calls the Federal Health Board a "standard setter," but, in fact, it would become the dictator as to who lives, and who dies.

Paralleling Daschle's proposal is a piece of legislation which was introduced by Sen. Jay Rockefeller (D-W.Va.) on May 20. Rockefeller proposes that the Medicare Payment Advisory Commission (MedPAC, created in 1997), move beyond its current mandate to advise on rates of payment for the 44 million enrollees in Medicare, to set lists of approved treatment standards, and enforce compliance with regulations on health-care delivery and reimbursement. Rockefeller's press release states that he wants MedPAC to be made up of "independent experts," as an "executive agency modelled after the Federal Reserve."

He adds: "We must take Congress out of its current role.... It is inefficient and ineffective; we are not health-care experts, and being a deliberative body means that we cannot keep pace with the rapidly transforming health-care marketplace."

Knew or Should Have Known

When the Nazi doctors, and others, were tried for crimes against humanity and genocide at the Nuremberg Tribunal after World War II, many claimed that they only had the most noble intentions; others, that they were only following orders. In fact, they were wittingly serving as "expert" or bureaucratic cogs in a mass-murder machine, of whose outcome they were fully aware.

While there is no doubt that the degeneration of our culture, in terms of the valuation of life, has proceeded quite a distance over the last decades, thus preparing our population to accept Nazi euthanasia today, the apparatus parallel to that which Hitler set up *can still be stopped.* It must be done now—before the medical and economic "experts" carry out genocide again.

Among the sources for this article were, A Sign for Cain, an Exploration of Human Violence, *by Fredric Wertham, M.D.; and* The Nazi Doctors, *by Robert Jay Lifton.*

nancyspannaus@larouchepub.com

Britain's NICE

Who Gets Medical Care, Who Dies

by Marcia Merry Baker

In the course of the decline of the physical economy of Britain over recent decades, a special mechanism was created in 1999—NICE (National Institute for Health and Clinical Excellence)—to enforce the reduction in medical treatment provided to Britons through their National Health Service (NHS), which was established in 1948. NICE decrees what drugs, devices, surgeries, and treatment practices are approved for the NHS, based on cost considerations, and what will be disallowed.

Better named, Nazi-Inspired Commoner Extermination, the ten-year-old NICE has been under attack year after year, by NHS patients, physicians, and hospitals alike. In just a decade, its policies of selective denial of cancer drugs, surgeries, kidney dialysis, and other treatments, have increased the death rate for whole age-groups and classes of Britons—which is a Nazi-medicine policy. This was its purpose.

Nevertheless, NICE is now being discussed as the model for inclusion in the U.S. health-care "reform." Those promoting a U.S.-version of the not-so NICE—e.g., a "Federal Health Board," or a Medicare Payment Advisory Commission with teeth, or any such variants—are simply serving the financial interests behind the policy of delimiting care, in order to keep the payments flow going to the "managed care" insurance networks now looting the U.S. medical system to the point of breakdown and death. And to kill people. The record in Britain is clear.

Tony Blair's Nazi NICE

NICE went into operation on April 1, 1999. It was set up through the Health Department of the Tony Blair government (1997-2007), under the propaganda claim that by determining what treatments were to be nationally allowed or not, this would even out the "disparity" in health-care costs and quality from one "post code" to another. As the NICE's own official history chooses to

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describe it, there was “inappropriate variation in the quality of care and unequal access to new treatment, depending on where you lived ... the government decided to form an organization to improve the quality of care that patients receive from the NHS in England and Wales.... When NICE was first established, many perceived its only role as rationing healthcare. But this was not the case....” (www.nice.org/uk)

What was the case, is that NICE cut care far beyond “rationing,” while the physical infrastructure for medical-care delivery was being cut back, in terms of staff ratios, diagnostic equipment, numbers of hospital beds, and so on. NICE has claimed that it is using “clinical effectiveness” among its criteria, but the truth is otherwise. Look at the functioning of the NICE Centre for Health Technology Evaluation, which, in its issuance of formal guidance on what medications will, or will not be allowed, has repeatedly and knowingly caused suffering and death. There are many examples.

- In the case of Alzheimer’s disease, NICE has tried to limit patients from using the drugs Aricept, Exelon, and Reminyl, by ruling that they can be prescribed only for those with moderate Alzheimer’s symptoms, but not those in the early stages of the disease. NICE brushed aside the research studies showing that patients have shown an “excellent response to treatment,” after just five months.
- In the case of breast cancer, NICE has tried to stop patients from having access to the drug Herceptin. After a big protest movement, limited NHS use was permitted in 2006.
- In the case of osteoporosis, NICE has restricted the use of the medicine Protelos.
- In the case of kidney cancer, the drug Sutent was disallowed. Following protests by physicians as well as patients, in January 2009, NICE acquiesced to permitting limited use.
- In the case of multiple sclerosis, NICE has ruled out beta interferon treatments. In 2001, it ruled that the “clinical benefits appear to be outweighed by very high costs” of the drug. Whereas 15% of continental European MS sufferers receive the drug, only 1% of such patients do in the U.K.

Physician Warnings: NICE Kills

A March 2009 *European Journal of Cancer* editorial attacks NICE, saying that the agency, in its rulings on which treatments are to be accessible, and under what conditions, has become more restrictive, year by year, and has increasingly based its rulings not on *clinical effectiveness*, but on *cost effectiveness*. Last year, to take only one example, NICE rejected four drugs for advanced kidney or lung cancer, while acknowledging, as reported in *The Independent* of London, that “the drugs do extend life by up to six months, but the money would be better spent on other patients.”

NICE has also progressively reduced accessibility of radiology treatments for cancer, causing those who have gone through chemotherapy to wait many months for radiation treatments, or to forgo them entirely. After six years of NICE, the wait for radiology had doubled to six weeks; after ten years, it had nearly doubled again to 11 weeks, according to the (U.S.-based) Commonwealth Foundation.

The results are clear in 2008 comparative studies by the Swedish Karolinska Institute and by the British College of Radiologists. Among women, 10-18% fewer Britons survive five years after breast cancer diagnosis, than women in other major European countries or the United States; the rates of survival range from 71% in France, down to 53% in the U.K. Among men, 10% fewer Britons survive various cancers for five years; the survival rates range from 53% in France, down to 43% in the U.K. Hundreds of thousands of lives are cut off early under NICE’s rulings.

An article warning the U.S. against the NICE model was written recently by London oncologist Dr. Karol Sikora, a professor of cancer medicine at the Imperial College School of Medicine. In a May 12, 2009 New Hampshire *Union Leader* article, “This Health Care ‘Reform’ Will Kill You,” Dr. Sikora said, “As a practicing oncologist, I am forced to give patients older, cheaper medicines. The real cost of this penny-pinching is premature death for thousands of patients—and higher overall health costs than if they had been treated properly....” He added, “If NICE concludes that a new drug gives insufficient bang for the buck, it will not be available through our public National Health Service, which provides care for the majority of Britons....

“Partly as a result of these restrictions on new medicines, British patients die earlier. In Sweden, 60.3 percent of men and 61.7 percent of women survive a cancer diagnosis. In Britain the figure ranges between 40.2 to 48.1 percent for men and 48 to 54.1 percent for women.”

To police British physicians and patients, who have repeatedly risen up to protest NICE, a new agency went into operation April 1, 2009, called the Care Quality

The Orwellian-named British health-care-slashing outfit NICE was established in 1999 to enforce deep cuts in medical treatment provided through the National Health Service. It is now the model for the Obama Administration's health-care "reform." The elderly man in the photo would likely be denied treatment for serious medical problems, due to his age.

Commission. Headed by Barbara Young, Baroness Young of Old Scone, the Commission has a wide range of enforcement powers under her command, to discipline physicians, hospitals, and others to stay in line with the NICE and related NHS "cost effectiveness" clampdowns.

NICE Mathematics of Death

Earlier this year, the chairman of NICE since its inception, Sir Michael Rawlins, was confirmed to stay on for another two years. He is playing his part to promote the NICE Nazi-medicine approach in the White House "reform" drive. In April, from London, he made a video presentation to a Health Channel TV Summit on U.S. health-care policy. *Time* magazine interviewed him on March 27, asking, "Why is NICE needed? Shouldn't you get the drugs you need when you are sick, regardless of cost?"

Rawlins: All health-care systems are facing the problem of finite resources and almost infinite demand.... We are best known [for looking] at a new drug, device or diagnostic technique to see whether the increment in the cost of that treatment is worth the increment in the health gain....

Time: How is that measured?

Rawlins: It's based on the cost of a measure called the "quality-adjusted life year." A QALY scores your health on a scale from zero to one: zero if you're dead and one if you're in perfect health. You find out as a result of a treatment where a patient would move up the scale. If you do a hip replacement, the patient might start at 0.5 and go up to 0.7, improving 0.2. You can assume patients live for an average of 15 years following hip replacements. And .2 times 15 equals three quality-adjusted life years. If the hip replacement costs 10,000 GBP [about $15,000] to do, it's 10,000 divided by three, which equals 3,333 GBP [about $5,000]. That figure is the cost per QALY."

Rawlins was asked by the interviewer, "You are basically deciding how much a year of life is worth?" He agreed, admitting that this is "controversial," but it has to be done.

UnitedHealth/AARP—NICE to USA?

One of Rawlins' collaborators, and originators of NICE, is now playing a leading role in exporting its concept to the United States. Simon Stevens is a British national, who today is a vice president for UnitedHealth Group, Inc., heading up its Ovations/AARP Medicare division. He worked in the Blair government from 1997 to 2001, as a policy advisor in the Health Department, during which time NICE was established. In 2001, Stevens moved directly to 10 Downing Street, and served until 2004 as Blair's advisor on national health policy. Stevens was considered an architect of what were called the NICE "reforms" of the NHS. In January 2007, he moved to Minneapolis, to his top position at UnitedHealth, to continue with his "reform" cost-cutting plans in the United States.

On May 27, Stevens announced proposals for how Medicare could cut costs for seniors, issued as a gesture from one of the top private insurance companies, on how to help President Obama find ways to save the government money, in the President's intended comprehensive health "reform" legislation. Stevens announced that UnitedHealth Group has established a new Center for Health Reform and Modernization to advance ways to cut costs, while providing universal health-care coverage.

Stevens said that his proposals could save $540 billion over the next ten years in government health-care

spending. Speaking for the UnitedHealth Group, which claims to finance and manage health care for over 70 million Americans, Stevens issued UnitedHealth's report, arguing that many of the cost-saving measures it is already using, could be applied to the Medicare program.

Stevens' report sets out 15 steps which, he claims, are the way to save over half a trillion dollars. Of his 15 steps, the largest grouping (6 steps) is under the category "Reducing Avoidable and Inappropriate Care."

marciabaker@larouchepub.com

Kill the HMOs To Cut U.S. Health-Care Costs

by Edward Spannaus

It is well-known, but little discussed, that the United States spends far more on health care per capita than any other country, yet ranks lower than any other industrialized country on most measures of well-being, including longevity. Indeed the rule-of-thumb is that the U.S. spends twice as much as European countries on health care, and has less to show for it.

The most glaring cost factor in the U.S. health-care system—which Obama Office of Management and Budget Director Peter Orszag and the rest of the White House Nazi doctors refused to admit—is the excessively high administrative costs charged by private health-care insurers.

Rather than cutting life-saving medical treatments to balance budgets, Lyndon LaRouche insists that it is this high overhead cost of our corrupt, private insurance-dominated health-care system which has to go, and that the only solution is to dump the HMOs (health maintenance organizations) and to go back to the Hill-Burton system of ensuring adequate medical infrastructure.

Numerous studies have shown that the administrative costs for Medicare—a government-run program—are about 2%, compared to 30% or more for private insurance. (Some have estimated that the total overhead and administrative costs for the private U.S. health-care system is as high as 50%!)

A Government Accounting Office study, already in the 1990s, found that the U.S. could save enough simply on administrative costs, with a single-payer national health program, to cover all uninsured Americans.

A 2003 study published in the *New England Journal of Medicine*, found that in 1999, administrative health care costs per capita were $1,059 in the U.S., compared to $307 in Canada. By one measure, administration was 31% of health-care expenditures in the U.S., compared to 16.7% for Canada's mixed public-private insurance system. Canada's national health insurance program had overhead expenditures of 1.3%; its private insurers, 13.2%. (The comparison is only useful up to a point, since the Canadian system rations some aspects of health care—which, if anything, *increases* its administrative costs; but overall, Canadians have more hospital care per capita than do U.S. citizens.)

The *NEJM* study found that it would save $209 bil-

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Rather than spend money on medical care for those who need it, the HMO system wastes 30% of its expenditures on overhead. Administrative costs for the government-run Medicare program, on the other hand, are estimated at 2%. Shown: Waiting for flu shots, Sterling, Va., October 2004.