Carter, to dissolve the Commerce Department and place its largest unit, the Economic Development Administration, under HUD, which in turn will be transformed into a Department of Economic Development.

Under this plan, HUD Secretary Harris — a former member of a Washington law firm with strong links to British intelligence — will have at her disposal huge amounts of money to dispense on the kind of "community counterinsurgency" programs for which HUD is becoming notorious.

Kennedy is building up his own power base on the chairmanship of the influential Judiciary Committee. Kennedy is also conducting negotiations for a seat on the powerful Budget Committee where, as an aide put it, "He'll be able to exercise fiscal restraint over every government program."

Though Kennedy's commitment to austerity is as ironclad as anyone's, there are indications that the Senator is simultaneously attempting to position himself at the head of the developing opposition to the Administration's austerity policies — obviously boosting his own presidential ambitions. According to Leon Shull, executive secretary of the Americans for Democratic Action, "Kennedy will lead the liberal forces against Carter this coming year." Shull also said that Kennedy will be "the silent collaborator" of the liberal-fascist groupings led by United Auto Workers head Doug Fraser and original poverty-pimp Michael Harrington which are expected to protest Carter's policies and boost the Kennnedy health insurance bill, in particular, at the Democratic Party's mid-term convention in Memphis Dec. 8-10. A source close to Shull confided that the so-called debate on health insurance between Kennedy and Califano which is a "highlight" of the convention is "just for show," since "Kennedy and Califano see eye-to-eye on the whole hospital cost thing."

— Kathleen Murphy

Defeating Kennedy's

How to fight the 'Kool-aid approach' to

The following is a policy statement submitted by Lyndon H. LaRouche, Jr., Chairman, U.S. Labor Party.

It is of the utmost urgency that the medical profession quickly develop and present a comprehensive alternate to the evil legislative concoction known as "The Kennedy Health Bill." The stress must be laid on the most evil feature of Senator Kennedy's proposals, proposals which may be fairly described in the aftermath of the Jonestown tragedy as the "Kool-Aid for the Aging" approach to slashing medical assistance to the senior citizens.

The model for this feature of the Kennedy bill is the pilot conducted at St. Christopher's Hospice in London. Yet, the more appropriate precedent is those features of Nazi Germany's medical practices during the 1930s which became the subject of the postwar Nuremberg Tribunal proceedings. The Nazi precedent shows that it is but one step from "Brompton Mix," as a medical cost-cutting measure, to the "cost-benefit" dictum of quickly terminating the existence of "useless eaters." The relevant provisions of the Kennedy proposal represent the wedge-end for such Nazi-like practices.

By emphasizing the hideous immorality of this included choice of policy-direction in the Kennedy proposal, we are able to draw public attention to the other dangerous and deplorable features of the whole body of this legislation. The inclusion of the blatantly immoral, evil feature aptly betrays the quality of philosophical outlook which has governed the design of the bill in all principal features.

Such an assault on the unspeakable evil of that proposed legislation could not be adequately effective by itself. The American voter must be given an acceptable alternative to the evil proposed legislation. It is not indispensable that an alternative comprehensive bill be presented. It is indispensable that a clearly articulated, factually grounded alternative *national medical policy* be elaborated for popular understanding.

It is my recommendation that a "Blue Ribbon Commission" be constituted, preferably by resolution of the assembled representatives of the medical profession.

I most strongly urge that the divisive issue of public and private health insurance not be the primary focus of the work of the Commission. Consideration of those matters should not be excluded, but should be included in a commission report as appended findings. The primary focus of the Commission's work should be the

Health Bill

health care for the dying

service of those ethical principles for which all honorable professionals stand in essential agreement, despite secondary divergences among them on the issue of financing the delivery of a quality of professional service on which all honorable professionals are generally agreed.

It should be stressed that the general public is divided on the issue of financing the delivery of professional health services. As long as the medical profession is drawn into making the financing of delivery the most prominent feature of the policy debate, the proponents of evil policies, such as the proponents of the Kennedy proposals, will demagogically exploit the issue of modes of financing delivery to obscure the deepest issues from public attention. The issue to be emphasized at this moment must be made the issue of *what is to be delivered.* After that fight for the *quality* of health services is won, we can settle the issue of financing delivery properly. Once we agree on the quality of what is to be delivered, we can judge financing of delivery by the standard of realizing the required quality.

The objective must be to mobilize the majority of trade unionists, farmers and others for the cause of maintaining and continuing to improve health services. Once that constituency for a basic national health policy is consolidated, the basis is established for resolving the subsumed policy-issues. *The object is to win.*

We know that there is a coherent connection between the modes of financing health services and quality of health services. At this point, the majority of the electorate does not. By winning a majority to a quality health services policy, we have laid the basis for promoting intelligent understanding of the economic problems, of producing qualified professionals and maintaining quality through appropriate modes of financing delivery. *The object is to win.*

The economics of health

It would be wrong to exclude the question of the economics of professional health services from the main body of the Commission's report. The matter of the cost of providing adequate, per capita health services is not directly the same issue as financing payment for delivery of those services to households and persons. I propose only to exclude the latter point merely from the main body of the Commission's report, not to exclude it from the separate recommendations on means of payment which I propose be appended to the main text as a part of the Commission's report as a whole.

What I contribute to this general purpose in the remainder of this proposal for a "Blue Ribbon Commission" is, and properly so, the advantage of my own special expertise: the economics aspect of medical cost trends.

I shall summarize the character of the economic disease responsible for inflation generally and for the explosion in services' costs, especially since the 1957-1960 period. By exploding popularized myths, I aim to draw the attention of medical professionals to those features of their own experience which corroborate my analysis.

AMA assails Kennedy health plan

This week's issue of the *American Medical News*, the official publication of the American Medical Association, devoted a front-page article to an attack on Senator Edward Kennedy's national health insurance plan, including quotes from a recently released U.S. Labor Party leaflet to tie Kennedy to the Jonestown murder-suicide cult.

Under the headline "Another Installment in Kennedy National Health Insurance Show," the AMA reported on hearings held by Kennedy on his National Health Insurance plan in Chicago. "Handed out" at the hearings, the article reported, was "a release from the U.S. Labor Party charging that Senator Kennedy and Henry Kissinger are behind the Guyana suicide cult, which, the release charges, is really nothing more than a 'right to die' campaign to promote the hospice concept."

Kennedy, charged the AMA, attempted to push the "Canadian health system," a program of "socialized medicine" premised on the reduction of health services nationwide. The Illinois Medical Society took issue with Kennedy, blasting the Canadian system as an attack on the American high-technology approach. The Canadian system is vastly inferior to the American, concurred the AMA publication. The journal quoted a Canadian physician who urged: "Do not bring American medicine down to the Canadian level."

I shall show that, apart from some considerations specific to health professions and institutions, the general, deeper reason for the explosion in apparent costs of health services per capita have nothing to do with the medical profession as such. Rather, the explosion in health-care costs is a conspicuous reflection and by-product of a dangerously wrong-headed national monetary and economic policy. The explosion in medical-care costs is but one much emphasized facet of a much broader general problem of economic policy.

I shall also show that, happily, a cure for the economic disease is now being brought within reach.

The most efficient point on which to focus attention initially, to understand the destructive fallacies of U.S. economic policy, is the imbecilities integral to our present National Income Accounting system, the so-called GNP system. I illustrate the point by pointing out that the legalization of dangerous drugs, such as marijuana, heroin, methadone, and other psychotropics for uncontrolled use on demand would automatically increase the reported GNP by more than $100 billion annually — without any other change but that legislative action. The legalization of present levels of illegal gambling would increase the reported GNP in a similar fashion. The legalization of muggings and burglaries, the legalization of hired assassination, and of other income-linked crimes would have identical benefits for the GNP estimates.

In brief, the present methods and standards of National Income Accounting make no distinction between useless or even destructive paid activity and those forms of production, distribution and services which augment our tangible national wealth and contribute to the well-being — and, hence, productivity — of our citizens.

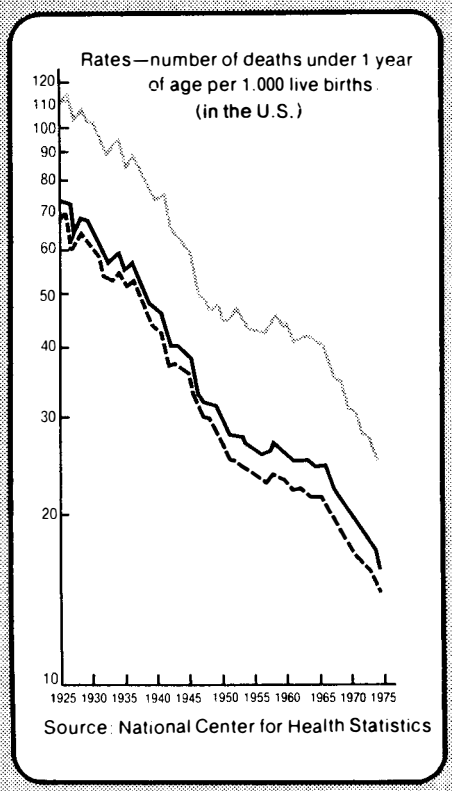
For example, if General Motors Corporation were to cease all production, but received a Health, Education and Welfare, or HUD grant to keep all its employees on the payroll for purposes of digging and refilling holes in the waters of Lake Huron, the idiot statisticians in Washington would prompt the White House to report with confidence that General Motors' shutting down tangible goods production had not caused any direct fall in its GNP contribution nor led to any increase in unemployment among its employees.

Admittedly, in the ordinary course of professional practice, neither educators nor physicians contribute anything directly to the gross tangible output of the United States' economy. Rather, those professions are essential to developing and maintaining the productive powers of our national labor force. Looking merely at this point of emphasis for the moment, let us consider the way in which education and medical services contribute in the most obvious ways to maintaining and improving our nation's potential productivity.

The educator's connection to improvement of the potential productivity of the labor force is direct and obvious. To begin to identify the physician's connection we need only consider the effects of lowering the mean level of life expectancy. This is not, of course, the whole picture; it is a point of reference through which we can bring the whole picture into focus.

The maintenance of a developing labor force correlates with an increasing number of years devoted predominantly to education. Granting that the number of years required to develop a qualified professional would be significantly reduced by better secondary-school education, a modern culture requires that the first 18 to 30 years of life be occupied principally with preparation for adult careers ranging from semi-skilled, technologically modern forms of employment to advanced forms of professional employment. This training represents two kinds of cost to the society as a whole. First, those under 18 to 30 years, as the case may be, must be sustained throughout that period through production by persons of more mature years. Furthermore, as the society develops, the content of education and other training must be intensified in respect of its technological components. This also correlates with the need for a higher standard of household and individual life in homes and communities, improved qualities of leisure, all as background prerequisites for advances in educability.

Infant mortality rates by color, 1925-74



All of this must be paid for out of the production contributed by the maturer layers of the population.

Imagine a modern United States trying to maintain its per capita output and technology under conditions in which the mean life expectancy fell into the forties or even the fifties! (Not so incidentally, we have identified one of the most critical problems of development in the Third World.) The longer the mean life expectancy, the more successfully medical science masters those diseases of aging, beginning with cancer and senility factors, the lower the per capita cost of maintaining each citizen in higher quality of life. It is to be emphasized that a gifted individual only begins to realize his matured mental potentialities during his forties and fifties.

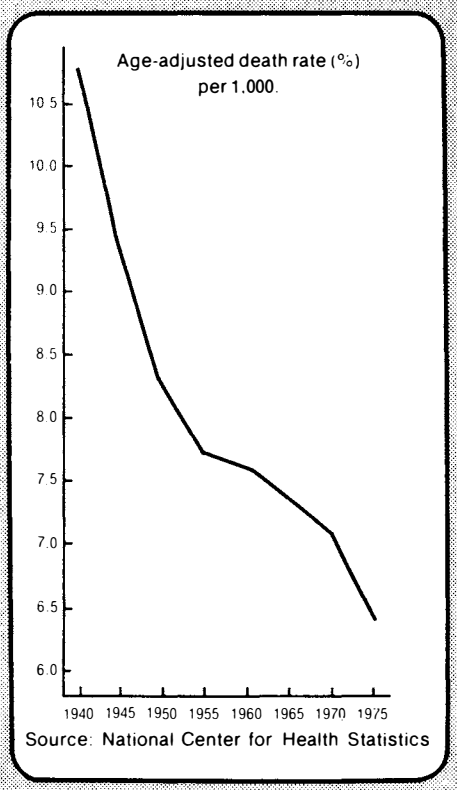
Education and medical services are a more or less well-defined, socially necessary cost per capita of the general population, for each qualitative level of advancement in the course of generalized scientific and technological advancement of social productive and other practice — without yet considering the exceptional, traumatic occurrences, such as wars — which impose increased burdens on medical practice.

For reason of fundamental theoretical-economic principles which I have outlined in summary in my *The Theory of the European Monetary Fund,* it happens that scientific progress, education, medical services increase as social costs per capita, but less rapidly than social productivity potentials of populations are increased through such services. Therefore, in a well-run economy the social costs of maintaining a constantly improving health service become increasingly less burdensome to the population, even though the relative share of total costs represented by health services must tend to rise.

This happy connection breaks down only if the benefits of health services are not being realized. That is, if a diminishing proportion of the total potential labor force of a society is actually being employed in useful production at levels of technology consistent with the population's technological potentialities. In the case of failure, the burden of maintaining quality medical services must appear to increase, becoming increasingly unaffordable. This crisis of medical costs does not originate within the practices of the health profession, but in the decay of the economy to which health services are provided.

Let us turn our attention back to the early 1960s, to the period in which such monstrosities as Robert Hutchins's "Triple Revolution" buncombe was being popularized. Recall those numerous foolish voices who insisted that the U.S. shift from emphasis on industrial

U.S. mortality 1940-75



Source: National Center for Health Statistics

Advanced health care works

Senator Ted Kennedy and other proponents of national health care legislation claim that the use of expensive, advanced technology in health care has gotten out of hand, with costs far outstripping benefits. They claim that health care should reorient toward improving diets, the environment, etc.

But the results of Medicaid and Medicare (which Kennedy wants to eliminate) provide a test of the effects of introducing advanced medical technology into segments of the population which contradicts Kennedy's claim. Following the passage of Medicaid in 1965, infant mortality plunged, as a combined result of better prenatal care and neonatal facilities, including the development and widespread use of neonatal intensive care hospital units. Included in the drop in infant mortality is the remarkable drop in low-birthweight mortality, which is directly correlated with the most advanced hospital technology, including monitoring equipment, incubators, and respirators.

Equally impressive is the fall in overall death rates of the aged population associated with Medicare. The increased health care expenditures for the over-65 population included a 47 percent increase in real hospital services from 1965 to 1975. Mortality figures show a significant drop off in overall mortality between 1970 and 1975, 9.9 percent, which was greater than the total mortality decrease for the fifteen year period 1955-1970, 8.0 percent. For the aged category, the changes in mortality are even more marked. The death rate for the aged during 1965-1975 fell 11.2 percent, compared to only a 2.4 percent decrease during 1950-1965.

Moreover, the life expectancy for 65-year-olds increased dramatically after medicare. In 1900 the life expectancy of a 65-year-old was 12 years; in 1950 it was 14 years. In the ten Medicare years, 1965-1975, it increased by 1.4 years to total of 16.1, an increase of more than 50 percent of the total increase during the entire period 1900-1965.

expansion toward a "services economy" was a praiseworthy and hopeful development. Recall the November 1967 collapse of the British pound, and the first official collapse of the dollar and Bretton Woods system during February and March of 1968. Recall the continuation of the "services economy" policy and developments into the August 1971 collapse of the dollar and the Bretton Woods agreements. Consider the way in which this downward spiral of basic economic decay in the U.S. economy has been covered over through White House and Congressional emphasis on the growth of GNP.

The worse the U.S. economy becomes, the more the GNP seems to expand. The imbecility of the cult-like worship of the existing National Income Accounting frauds is reflected into reality by galloping inflation. Since an ever smaller portion of the total labor force is actually engaged in high-technology progress in productive employment of tangible output, the social cost of producing an average material standard of living is spiraling upward. The result is reflected into the monetary realm as inflationary deterioration of the standard of living.

This inflationary process must affect the education and medical professions most severely. Both professions are not only labor-intensive forms of services, but both require the relatively highest amount and intensity of training of the qualified professional. The cause of the rising relative cost of the professional hour is not generated within the medical profession. It is the result of an inflationary decay of the general economy, a result which must be most greatly amplified in those forms of services which reflect the highest intensity of training and training costs.

As the medical profession attempts to combat this problem, a further complication of general inflation is introduced. Improvement of the productivity of medical professionals involves the same principles as improvement of the productivity of skilled labor in the plant, advances in the per hectare and per capita productivity of farmers, and so forth. Not only do we concentrate on advances in medical-scientific knowledge. We require various products of scientific research and high-technology manufacture as tools of the medical profession.

These improved tools of diagnostics and therapeutic practice are cost-reducing in reality. The unit-hour of mean professional medical service is accelerated in the intensity of benefits delivered to the patient during that hour. Yet, according to misguided accounting practices and other dubious services of information, it is these improvements which are being blamed largely for the inflation in medical costs.

Let us consider the accounting absurdities first. By what demented kind of argument is it proposed that it is cheaper *in net social cost* to construct a clinic with a low level of supporting services than to add the equivalent patient capacity to a modern general hospital? It is past time that physicians ceased permitting themselves to be diagnosed by idiot savants of the accounting profession, and perhaps donated a few words of clinical advice to relevant elements of the accounting profession. What are these imbecilic fictional assumptions of accountants which lead to such clearly absurd results?

The point is that high-technology facilities and supporting services are a resource for the entire population of the serviced municipality or county. To deliver these essential means to that community, we must locate these facilities somewhere in that community. So, some progressive hospital or clinic assumes the burden of this on behalf of the entire community. This cost is properly defrayed by applying it to all the hospital beds, outpatient facilities and so forth which are involved. The fact that the clinic which does not utilize such facilities has an apparent lower capital amortization per patient-day does not, by any stretch of the imagination, prove that the high-technology general hospital or advanced clinic is "overcharging," or driving up medical costs with "excess equipment."

More directly to the point of inflation, the institutional and equipment costs of medical services are monstrously inflated by effects of inflation on real estate speculation, by financing costs generally, and by skyrocketing medical-insurance costs — whose actuarial fictions are sometimes the extreme of monstrous illogic. They are also increased through the high costs of producing too small an amount of high-technology equipment. For example, if U.S. health facilities had an adequate number of body scanners in use, body scanners would be much cheaper, and improvements in them would come faster and more cheaply.

The duty of the medical profession — and of national policy-makers — is to encourage the medical profession to promote high rates of expansion of services and high rates of improvement in basic research and in high-technology equipment. It is the economy which is sick, not the medical profession. With a return to emphasis on generalized scientific and technological progress, and emphasis on high-technology forms of employment in production of useful tangible goods, the economy will begin to be cured of its own disease, and with that development the *burden* of medical services will begin to evaporate.

What is threatening to produce a biological holocaust in this nation is the "services-oriented," "environmentalist"-oriented policy of Senator Edward Kennedy and his friends. Since the anti-industry, anti-capital formation policies of Senator Kennedy and his friends have wrecked our economy for the moment, Mr. Kennedy and his friends purport to discover that it is the "useless eaters" among the critically ill and the aging who must be triaged. It would appear that the greatest single contribution Mr. Kennedy could make to reducing medical-cost ratios of real national income would be to resign from political life.

The context for solution

One step toward solving the problem before us would be to junk the present National Income Accounting system and the doctrines associated with it. As a subordinate measure, existing standard medical and related accounting practices demand fundamental revisions.

The basic feasible solution to the economics of health services lies entirely outside the medical profession. We must treat the sick economy, rather than focusing on the symptomatic reflections of a sick economy into a medical profession. The symptomatic treatment proposed by the "fiscal austerity" fetishists must be seen as akin to eliminating diseases by killing the patients afflicted with those diseases.

The key to the cure of a "sick economy" is now being presented to the United States by the authors of the European Monetary System. The new system, to begin the first, two-year phase of initial, institutionalized operations on Jan. 1, 1979, is designed to be more than a new monetary system of the nations of western continental Europe. It is designed to be the seed crystal for a new world monetary system, a system to replace the bankrupt vestiges of the old Bretton Woods System. On condition that the United States enters into increasing cooperation with this new system, the dollar will be brought back over a period toward a 3.00 deutschemark level, and levels of U.S. high-technology exports will be expanded in the order of more than $100 billions annually.

The key to the new system is its emphasis on increasing the rates of high-technology capital formation in the industrialized nations through developing high levels of high-technology exports into the developing sector. The program for the North-South economic cooperation proposed covers an initial 25-year period, followed by a second period. By the close of the second period — approximately 50 years — the accumulated effects of high-technology improvements of agriculture and development of nuclear energy-centered industrial development will have brought the southern hemisphere into approximate parity in levels and rates of economic development with the presently industrialized sector.

I outline the principles which make this entirely feasible in my *The Theory of the European Monetary Fund.*

By repealing those legislations and administration policies which are currently reducing annual U.S. industrial exports by several tens of billions annually, and by making use of low-interest (5 to 7 percent) credit available to U.S. investors and exporters through the new monetary system, the increased exports in the order of $100 billion or more annually are rather quickly reached over the next two years. This export boom is the basis for a boom in internal capital-formation rates. This is the level needed to shift the emphasis in employment away from services and waste toward skilled employment in production of tangible wealth.

With increased ratios of the labor force employed in high-technology tangible output production, and with an accompanying emphasis on increased rates of capital-formation and technological advances, the conditions are provided for straightening out the internal economy.

The medical profession should consider identifying itself with the European Monetary System's policies on behalf of vital U.S. interests. Meanwhile, the "Kool-Aid" aspects of the Kennedy Health Bill should be emphasized to the point of mobilizing popular rage against the bill. Meanwhile, the medical profession would be well-advised to establish a "Blue Ribbon Commission" for the purposes indicated above.

—Dec. 4, 1978