

Health Letter

SIDNEY M. WOLFE, M.D., EDITOR

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What are the Presidential Candidates Talking About? A Brief Dictionary of Health Policy Terms

As the presidential debates heat up and health issues assume a higher political profile, candidates are coming up with strategies to reform the current health care system. Some of these fundamentally redesign the way in which care is financed and paid for; most, however, tinker with the system, providing only partial solutions to lower the number of uninsured, control costs, and increase accountability. These proposals are likely to be subjected to much debate, and some phrases or concepts will be over-used and abused. We are therefore providing our readers with a basic dictionary of the current health policy vocabulary.

Choice: is as American as apple pie. In the health policy arena, however, the word is usually a code for the provision of a variety of options, some of which offer skimpy services or deceptively low premiums. Although appropriate and timely information is essential to true choice, many plans violate this basic tenet. They are confusing, complicated, and jargon-ridden; as a result, patients often have problems finding out what is covered and under what circumstances.

At the policy level, an insistence on "choice" often serves as the rationale for avoiding a uniform service package and universal coverage. It is also the entry point for strengthening health

savings accounts (see below). Attempts to privatize Medicare also parade under the banner of "choice." This accounts for the creation of Medicare Advantage Private Fee-for-Services plans. These cover extra benefits and cost more than traditional Medicare. Indeed, Medicare pays an average of 12 percent more for those who enroll in Medicare Advantage plans than it pays for beneficiaries who are covered under traditional Medicare. These plans have been beset by aggressive, inappropriate marketing activities. After many senior advocates complained that some beneficiaries were inadvertently finding themselves in plans in which they did not want to enroll, whose coverage they did not understand, seven insurance companies agreed to stop marketing private Medicare plans temporarily. Nevertheless, there is still much confusion disguised as "choice."

Consumer "buy-in": This phrase, used to justify greater cost-sharing, assumes that paying out-of-pocket will make consumers more aware of the costs of health care, thereby making them more prudent consumers. Additionally, "buying in" is intended to reinforce their role as stakeholders in the delivery of care. The problem is that this makes consumers responsible for deciding their spending priorities (most often with limited information), distinguishing between needed and unneeded care, and unbundling complementary services that work only as a package.

Cost-sharing has more of an adverse effect on those in poor health. It promotes delays or decreases in health care, resulting in adverse health outcomes. A 1999 study on the burden of Medicaid drug copayments found that elderly and disabled

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Medicaid recipients who resided in states which required copays had significantly lower rates of drug use than their counterparts in states without copayments. The main effect of the copay was to reduce the likelihood that Medicaid recipients would fill any prescription during the year, and the burden fell disproportionately on the ill. A more recent compilation of studies on cost-sharing and use of prescription drugs found that cost-sharing is associated with lower rates of drug treatment, lower adherence rates, and more frequent discontinuation of therapy. Moreover, for patients with certain conditions (e.g., congestive heart failure, diabetes, schizophrenia), higher cost-sharing ultimately results in more use of medical services, thereby offsetting any savings accrued from lower drug expenditures.

Cost-sharing also affects providers who serve low-income patients. Providers are placed in the uncomfortable position of charging those they know cannot afford to pay, or assuming a financial loss for care to the poor.

Consumer-driven health care:

This term characterizes health schemes that give greater responsibility to patients for the costs of their health care. Usually, this takes the form of higher co-pays or deductibles, which are intended to make the consumer more cost-conscious. These high-deductible plans are often paired with *health savings accounts* (see below).

High-deductible plans have a number of perverse effects. Because they pay for high-ticket items rather than for more basic services (e.g., amputations rather than visits to podiatrists), they distort the supply and demand of care. In addition, cost-sharing can raise barriers to care, which in turn lead to late or no services (see also *Health savings accounts*). Moreover, high deductibles tend to have a differential impact on women, who have a greater need for preventive services, not all of which may be covered. A recent study compared out-of-pocket expenditures for maternity care under five different plans, four of

which had high deductibles. The researchers found “tremendous variation” in the financial burdens the plans impose, and concluded that “women and families could be left with thousands of dollars of expenses from maternity care even with an uncomplicated birth, resulting from the high deductibles and cost sharing requirements in these plans.”

Cost containment: Because many politicians, researchers, and analysts agree that much medical care is ineffectual or inappropriate, cries for cost containment come from a variety of sectors and result in strange bedfellows. Conservatives favor cost-containment measures as a way of shrinking the public sector and unleashing market forces. More politically progres-

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sive segments of the population consider cost containment a tool to better monitor health care, avoid unnecessary services, and free up resources that can then be used to cover more persons or broaden the scope of services provided. Because many disparate and even conflicting measures fall under the rubric of “cost-containment,” it is best to ask *Cui bono?* (*To whose benefit?*) when assessing these strategies.

Cost-containment strategies also differ in terms of their target: some are aimed at consumers, others at providers. Those that seek to modify consumer behavior try to reduce consumption of services (see *Consumer-driven care*, above). Others

address physician behavior by reimbursing them for certain outcomes rather than the number of services they provide. At present, for example, Medicare is carrying out an experiment which rewards doctors “for the quality of care they deliver rather than how many tests and procedures they perform.” The idea is to provide financial incentives to encourage doctors to help patients avoid costly hospital stays or emergency care through more timely monitoring of conditions and better coordination of services. Of 10 physician groups taking part in the experiment, which is still in process, all improved care for patients during the first year, but only two earned bonus payments because of monies saved. It is therefore unclear if the financial incentives work or not. Remaining issues include the fact that physicians were uncertain as to what they had done to generate savings, and rewards went to organizations rather than to the individual doctors.

Disease management: Under most health systems, a small fraction of those covered account for a large share of all costs. Thus, for example, 4 percent of Medicaid enrollees consume half of all Medicaid expenditures. Similarly, a survey among a group of large employers found that 72 percent of workers and their families accounted for only 11 percent of employer health-care expenditures annually, while the top 4 percent of users represented 49 percent of total employer costs. Program administrators are therefore eager to make a dent in the demand from those “high users” in order to reduce their disproportionate expenditures on this fraction of their enrollees. “Disease management” has been proposed as a tool to do this, and many providers are experimenting with ways to manage those with specific diagnoses or who are frail or have multiple chronic conditions. The aim is to improve health and prevent disability as well as to keep costs in check.

Because of its potential, disease management has become somewhat of a growth industry, and established plans have incorporated disease-

management efforts within their offerings. At the same time, for-profit companies have sprung up to sell their services to employers and health plans who want to keep their employees healthy and their medical costs down. As self-contained entities separate from health care, these companies promote patient education and more effective self-management through phone calls and the internet. In 2005, two-thirds of employers with staffs of 200 or more offered disease management as part of their job-based insurance plans; more than 20 states have some kind of disease management for their Medicaid enrollees.

There is growing interest in assessing the efficiency and efficacy of these programs, and several studies have focused on whether or not they improve health and lower costs. Studies looking at disease-management initiatives in the Group Health Cooperative in Seattle and in the Kaiser Permanente program in Northern California found that quality of care improved, but there were no cost savings. A current, ongoing study by Mathematica Policy Research is testing whether disease management can lower costs and improve patient outcomes and well-being in the Medicare fee-for-service population. To date, the researchers have found that, while both patients and physicians are very satisfied with the efforts, few programs have had any detectable effects on patients' behavior or the use of Medicare services. Only one program had statistically significant reductions in hospitalization, and none reduced costs. The available data therefore suggest that, whatever the benefits of disease management on patients' health, they do not necessarily translate into savings.

Electronic health records, other IT Technology: Digital patient records provide a way to store a person's medical history, including chronic conditions, test results, prescriptions, contraindications, diagnoses, procedures, and physicians' comments. Some "smart cards" can hold the equivalent of 30 pages of medical records. The

In short, while health information technology has the potential to improve quality; reduce the costs associated with inappropriate care and medical errors; and boost administrative efficiency, information-sharing, and decision support, it is not a panacea for the system overall.

Secretary of Health and Human Services has called this technology "the most important thing happening in health care." EHRs have also received the blessing of Senator Hillary Rodham Clinton, and former Republican leaders Bill Frist and Newt Gingrich. What is it about EHRs that unites otherwise political opponents? Undoubtedly, the promise of easily portable, complete information that can be shared, searched, and analyzed is appealing to researchers and decision-makers alike.

Nevertheless, the changing dynamics triggered by this technology could have unexpected costs. While a RAND Corporation study found that EHRs could reduce errors and save about \$80 million a year, other experts caution against overstating the cost-saving aspects of the electronic record. As economist David Cutler has pointed out, "there is money to be saved, but it is not going to be cheap." Even cost-saving products require an upfront investment, and EHRs will achieve their payoff only over the long-term, if at all. Physicians in solo practice or in small groups may find it prohibitive to shift to EHRs without passing on the costs to consumers. While efficiency may be seen as socially desirable, many individual providers will lack the financial motivation to streamline and upgrade their practices. Another potential inflationary effect of the electronic technology is that better information may lead to more care for more people, and create a demand for given drugs in small markets.

Moreover, some experts feel that too much emphasis is being put on the "technological fix" that EHRs and other health-related IT represent, and that

we should not be lulled into thinking that that is a substitute for real reform in how care is delivered and paid for. In short, while health information technology has the potential to improve quality; reduce the costs associated with inappropriate care and medical errors; and boost administrative efficiency, information-sharing, and decision support, it is not a panacea for the system overall.

Health savings accounts (HSAs): This mechanism, ostensibly aimed at encouraging the uninsured to acquire coverage, allows those who buy high-deductible plans to deposit money, tax-free, into savings accounts that can be used to pay medical bills. If you don't spend the money in the account, you get to keep it. This 'solution' has been touted by the Bush administration as a tool to address the dwindling number of persons who have employer-sponsored health coverage. This proposal was best described by Stephen Colbert on Comedy Central: "It's so simple. Most people who can't afford health insurance also are too poor to owe taxes. But if you give them a deduction from the taxes they don't owe, they can use the money they're not getting back from what they haven't given to buy the health care they can't afford."

These accounts benefit mainly the more affluent segments of the population, who have more to gain from tax breaks. Moreover, HSAs encourage the healthy and the wealthy to drop out of company health plans, further undermining the weakened system of job-related coverage by depriving the

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HEALTH POLICY TERMS, from page 3 insured pool of those who are at less risk for illness and high-cost care.

Incrementalism: This refers to any policy that proceeds gradually in stages, usually by covering a growing group of people or an expanding array of services.

Many national health plans began as incremental efforts: some covered only workers in certain occupations, gradually expanding coverage to cover the entire labor force and then the rest of the population. When the US enacted Medicare and Medicaid, some expected that this would be the first step in achieving universal coverage. And when Medicare was extended to cover those with end-stage renal disease in 1972, there was some discussion concerning whether the US would be the first country to provide universal coverage on a disease-by-disease basis.

Incremental change has been hailed as “the American way” of addressing health care. Some have proposed covering children first and having them age into an expanding system. Others have suggested that progress is more likely to proceed on a state-by-state basis. In addition to creating a patchwork of systems that stop at state boundaries, the latter option will exacerbate existing geographical disparities. Moreover, state programs are relatively impotent to make the changes that are necessary to cover everyone and control costs. Only a national program will have the leverage to do this, and only a national program will give meaning to the concepts of “one nation,” equal opportunity, and equal protection.

Individual mandate: This refers to a state requirement that all residents buy health coverage or face financial penalties, and is similar to the requirement that all licensed drivers have car insurance. In 2006 Massachusetts became the first state enacting legislation mandating such coverage. Other states, however, are considering similar legislation. Passed with surprising bipartisan support, the Massachusetts law requires all uninsured persons within

the state to buy coverage by July 1, 2007. [All businesses with more than 10 employees that do not provide insurance are also mandated to contribute up to \$295 per employee per year to the state (see *Pay or play*, below)]. The legislation stipulates

Market-driven solutions: These solutions seek to transfer to consumers the monies now spent on their behalf for the purchase of health care. Those who favor this approach argue that the health sector has much to learn from other sectors

“The market functions wonderfully when we want to sell more cereals, cosmetics, cars, computers, or any other consumer product. Unfortunately, it does not work in health care, where the goal should hardly be selling more heart bypass operations. Instead, the goal should be to prevent disease and illness. But the money is in the treatment — not prevention — so the market and good care are at odds.”

— Donald L. Bartlett and James B. Steele

that individuals who do not comply with the insurance requirement lose their personal tax exemption; furthermore, they face fines for each month that they are uninsured. There is one loophole, however: no one is compelled to buy insurance if he or she cannot find affordable coverage. Initially, the state did not define what “affordable” meant. But subsequent research has defined the upper bound of affordability at 8.5 percent of income, which is what middle-income people pay for health insurance, including cost sharing. This loophole in effect exempts a sizeable fraction of the uninsured — 20 percent — from the mandate, thereby excluding them from coverage. At present, enrollment of those previously uninsured has been lagging. Because almost half of the uninsured in Massachusetts are single males, the state has enlisted the Boston Red Sox in its publicity campaign, thereby stressing the need for Massachusetts’ residents to “get in the game.”

of the economy, and that following the lead of other manufacturing and service industries will produce the “quick, courteous, consistent, low-cost service” that has made the US globally competitive in other markets. Yet, even some who are pro-market concede that health care is the part of the public sector where market forces have had the most limited success, largely because of distorted incentives and information failures. In addition, most often it is doctors rather than patients that decide what care is needed, and how much of it. Indeed, it is estimated that physicians control over 80 percent of health care spending on hospital care, prescriptions, nursing home, testing, and their own services.

Paul Krugman has succinctly pointed out that the health care insurance market does not work because of three things: risk, selection, and social justice. “Risk” refers to the fact that, in any given year, only a small part of the population will incur major medical costs. Those

who happen to be at high risk need good insurance if they are not to go bankrupt. But the insurance business is market-driven to cover only the healthy, pay out as little as possible for health care, and raise prices for the unhealthy. It therefore selects the “better risks” that will place fewer demands on the health system and cost less. “Social justice” refers to the widely held value that no one should be denied care because they can’t afford it. So government subsidizes a growing proportion of health care, although the US does this imperfectly, in a far-from-transparent way, and, most often, grudgingly.

Donald L. Bartlett and James B. Steele describe the problem as follows: “The market functions wonderfully when we want to sell more cereals, cosmetics, cars, computers, or any other consumer product. Unfortunately, it does not work in health care, where the goal should hardly be selling more heart bypass operations. Instead, the goal should be to prevent disease and illness. But the money is in the treatment – not prevention – so the market and good care are at odds.”

Medicare-for-all: describes a national health system which covers everyone through single-payer financing. This proposal builds on the foundations of the program enacted 42 years ago and therefore capitalizes on the familiarity and popularity of the current Medicare. Moreover, Medicare is run much more efficiently than private insurance plans: it operates

with less than 5 percent overhead, compared with the 15-30 percent dedicated to administration and profits in commercial health insurance plans. This would fundamentally change the way in which care is provided and paid for by getting businesses out of health care altogether. As Ezekiel Emanuel and Victor Fuchs have stated in their support of this option, “Health care is not part of [businesses’] core competencies but something they use as part of their labor relations. It creates job lock and distorts employers’ hiring and firing decisions.”

Our hesitation about Medicare-for-all – and the reason we prefer a single-payer program (see *Single Payer*, below) – is that Medicare has now started moving toward the inclusion of for-profit HMO’s as one option for patients, diluting the single-payer effect.

“Pay or play”: refers to proposals adopted or under consideration by states that require businesses to provide workers health insurance (‘play’), or pay into a government fund that will do it for them. The latter is most often called a Fair Share Health Care Fund. In some states, the legislation has been limited to very large employers (e.g., those with 10,000 employees or more); but other states (e.g., Massachusetts) have cast a broader net in an attempt to cover more of the uninsured. The proposal has elicited a variety of responses from different interests, and there are conflicting opinions even within the business community. While some employers regard “pay or play” as an ideologically offensive mandate,

others see it as a way to protect their own interests. The latter are those who cover their employees but are undercut by competitors who have lower labor costs because they do not provide health insurance to their workers.

Single payer: describes a financial system in which one entity acts as single administrator, collecting all health bills and paying out all health care costs. This would streamline administration, eliminating the complexity of having thousands of intermediaries with different billing systems, forms, and requirements. A single-non-profit plan is based on the original concept of insurance: creating a large buying pool to spread the financial risk of sickness so that no one faces a crisis when a health need strikes. The public agency would negotiate and pay the bills, exerting the leverage provided by being a powerful buyer to control costs and insure quality control. It would not employ providers or own health care facilities. At present, both traditional Medicare and the Veterans Health Administration operate as single payers, thereby cutting their administrative expenses. Single payer systems have been praised not only for their managerial simplicity but also for serving as “the ideal vehicle for implementing an egalitarian social ethic.”

Universal coverage: means that everyone is covered. Few proposals accomplish this. But calling plans “near universal” or “quasi-universal” is a contradiction in terms. ■

Editor.....Sidney M. Wolfe, MD
 Managing Editor.....Kate Resnevic
 Contributors.....Annette Ramirez de Arellano, DrPH
 Sidney M. Wolfe, MD
 Proofreader.....Sbilob Stark
 Production Mgr.....Kristy I. Jackson
 Public Citizen President.....Joan Claybrook

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Product Recalls

June 24, 2007 — July 18, 2007

This chart includes recalls from the Food and Drug Administration (FDA) Enforcement Report for drugs and dietary supplements, and Consumer Product Safety Commission (CPSC) recalls of consumer products.

DRUGS AND DIETARY SUPPLEMENTS

The recalls noted here reflect actions taken by a firm to remove a product from the market. Recalls may be conducted on a firm's own initiative, by FDA request or by FDA order under statutory authority. If you have any of the drugs noted here, label them "Do Not Use" and put them in a secure place until you can return them to the place of purchase for a full refund. You can also contact the manufacturer. If you want to report an adverse drug reaction to the FDA, call (800) FDA-1088. The FDA Web site is www.fda.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Recalls and Field Corrections: Drugs — CLASS I

Indicates a problem that may cause serious injury or death

Name of Drug or Supplement; Problem; Recall Information

Listerine Agent Cool Blue Plaque-Detecting Rinse, Glacier Mint Flavor, 250 mL and 500 mL bottles; Firm's testing confirmed microbial contamination in some bottles, including gram negative organisms. McNeil PPC, Inc.

RHINO V MAX (also labeled as RHINO V.MAX), Energy Enhancer Dietary Supplement, 5 and 15 capsules blister pack cartons; Unapproved New Drug; Product found to contain Aminotadalafil, an analogue of tadalafil, a drug product to treat erectile dysfunction. MegaCare, Inc.

V.MAX Herbal Stamina Enhancer for Men Dietary Supplement, Cordyceps Militaries, L-Arginine, Psyllium Husk Powder, Licorice Root, Astragalus Membranaceus, Steamed Panax Ginseng, Zinc Oxide, 0.5g, 15 Capsules cartons; Unapproved New Drug – product has been found to contain Aminotadalafil, an analogue of tadalafil, a drug used to treat erectile dysfunction. Lot #: VM0501, MegaCare Inc.

Recalls and Field Corrections: Drugs — CLASS II

Indicates a problem that may cause temporary or reversible health effects; unlikely to cause serious injury or death

Name of Drug or Supplement; Problem; Recall Information

Alupent® Inhalation Aerosol, (metaproterenol sulfate, USP) Inhalation Aerosol with mouthpiece, Net Contents 14g (10 ml), Metered Dose Inhaler, 200 metered doses; Product failed particle size distribution analysis during stability. Lot #s: 050912W, exp. date 12/2007, 060359W, exp. date 06/2008; Boehringer Ingelheim Corp.

Oxycodone Hydrochloride Extended-Release Tablets, 10 mg, packaged in 100-tablet bottles, Rx only; Mislabeled; a bottle labeled to contain Oxycodone Hydrochloride Extended-Release Tablets actually contains Opana ER (oxymorphone hydrochloride). Lot # 400586NV; Novartis Consumer Health Inc.

CONSUMER PRODUCTS

Contact the Consumer Product Safety Commission (CPSC) for specific instructions or return the item to the place of purchase for a refund. For additional information from the Consumer Product Safety Commission, call their hotline at (800) 638-2772. The CPSC web site is www.cpsc.gov. Visit www.recalls.gov for information about FDA recalls and recalls issued by other government agencies.

Name of Product; Problem; Manufacturer and Contact Information

All-Terrain Vehicles. The flange, which holds the fuel pump in the fuel tank of Kawasaki KFX450R All-Terrain Vehicles (ATV), can fail to stay connected to the tank itself. This can create a fuel leak, which poses a fire hazard to consumers. Kawasaki Motors Corp., (866) 802-9381 or www.kawasaki.com.

Brake Cylinder. The 190 Radial Brake Master Cylinders (used on off-road motorcycles) on the off-road motorcycle can crack and result in brake failure. This poses a risk of severe injury or death to the driver. Gustav Magenwirth GmbH, (800) 448-3876 or techquestion@magurusa.com.

Built-In Ovens. Thermador® Brand Built-In Ovens can have gaps in the insulation where overheating can occur and when used in the self-cleaning mode it can cause nearby cabinets to overheat. This can pose a fire hazard to consumers. BSH Home Appliances Corp., (800) 701-5230 or www.thermador.com.

Candles. There are no instructions on the Cinnamon Spice Candles warning consumers to remove the cinnamon sticks and trim the wick before lighting the candle. The cinnamon sticks can ignite, posing a fire hazard. Vance Kitira International, (800) 646-6360 or <http://vancekitira.com>.

Ceramic Space Heaters. Lasko Ceramic Heater's cord can overheat where it enters the base of the unit, which could pose a fire hazard to consumers. Lasko Products Inc., (800) 984-3311 or www.Laskoproducts.com.

Children's Clog Shoes. Plastic rivets used to attach the strap to the Toddler Clog Shoes can detach, posing a choking hazard to young children. Payless ShoeSource, Inc., (800) 654-0697 or www.payless.com.

Children's Earrings. Sleeping Beauty Crown and Cinderella Star Earring Sets contain high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Uncas Manufacturing Company, (800) 776-0980 or skenny@uncas.com.

Children's Metal Jewelry. Essentials for Kids Jewelry Sets contain high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Future Industries, (800) 929-0006.

Cooking Torches. Butane fuel can leak from the BonJour(r) Professional Culinary Torches near the nozzle, posing a fire hazard. Meyer Corporation, (800) 226-6568 or www.meyer.com.

Flashlights. The batteries packaged with the Xenon Aluminum Flashlights are labeled as "Panasonic CR123A Industrial Lithium" and have been determined by Panasonic to be counterfeit. The counterfeit batteries can overheat and rupture, posing a fire and burn hazard to consumers. Sportsman's Warehouse, (877) 678-0010 or www.sportsmanswarehouse.com.

Folding Recliner Chairs. Rockingham Deluxe Lounge Chairs (also sold as Vanderwall Folding Recliner Chairs) can collapse or fall backward due to faulty support brackets or weak frames, posing fall and severe laceration hazards to consumers. Bond Manufacturing Co., (866) 771-2663 or www.bondmfg.com.

Hammock Stands. The foot brackets on the Hammock Stands can crack or tear, causing a consumer to fall to the ground. The Algoma Net Co., (800) 800-7083 or www.algomanet.com.

Magnetic Building Sets. Small magnets inside the plastic sticks of Mag Stix Magnetic Building Sets can fall out. Magnets found by young children can be swallowed or aspirated. If more than one magnet is swallowed, the magnets can attract each other and cause intestinal perforation or blockage, which can be fatal. Kipp Brothers, (800) 428-1153 or www.kipptoys.com.

Microwaves. Internal electrical arcing in Sunbeam Over-the-Range Microwaves can pose a fire hazard to consumers. Petters Consumer Brands LLC, (866) 866-6283 or www.sunbeammajorappliances.com.

Power Tool Batteries. If a vent on the Milwaukee Power Plus, Chicago Pneumatic, and Extractor 14.4 and 18 volt 2.4 Ah NiCd battery packs is damaged or compromised during use, the battery can explode and pose a laceration hazard to consumers. Milwaukee Electric Tool Co., (800) 729-3878 or www.milwaukeetool.com.

"Soldier Bear" Toy Sets. Surface paints on the Soldier Bear Brand Toy action figures, dinosaurs and animals contain high levels of lead. Lead is toxic if ingested by young children and can cause adverse health effects. Toy Century Industrial Ltd., (800) 866-3605 or www.aafes.com.

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Now, Let the Victim Beware

The following article is an excerpt from an article that appeared in the September/October 1978 issue of Mother Jones Magazine, written by Health Letter Editor-in-Chief and Director of the Health Research Group, Dr. Sidney Wolfe. All figures are accurate as of 1977; some have been updated and appear in brackets.

Most people are bewildered and frustrated about it. They're cynical, they're angry. They're looking for scapegoats, and they blame the victims. This is new, this concept of blaming the victim – the idea that people are bound and determined, with very little corporate help, to kill themselves. It's a false concept, but there are so many false concepts nowadays. What am I talking about? What else but cancer. Over the past few years, we've been barraged by a long list of things said to cause our most dreaded disease, cancer: food additives, drugs, workplace and household chemicals. Since 370,000 of us each year [1977 data – now much higher] die of cancer – that's 1,000 a day, there is cause for alarm. But there is even more cause for action. For decades the advertising industry, about \$38 billion of our GNP [now over \$150 billion], has oversold us on the benefits of commodities that have been found to cause cancer. Industry has held back information manufac-

turers didn't want to talk about. Sometimes information about risks didn't exist – not because science wasn't far enough advanced to test products, but because the manufacturers didn't want to know the truth. When things that have been around for decades or centuries, and that we've grown to love, turn out to cause cancer, it is overwhelming to most of us. When people get overwhelmed, they put up defenses to protect themselves. Three of the most common defenses against worrying about the cancer barrage are found in ways industry "helps" people to ignore animal evidence of cancer:

"Everything – if given in large doses to animals – causes cancer."

This statement is totally false. Government sponsored research has shown that only ten to 20 percent of chemicals *suspected* of causing cancer actually produce cancer in large-dose animal experiments. But if you tested *all* chemicals, suspect or not, the percentage causing cancer (even in large doses) would probably not exceed one or two percent of the total. Large doses will almost always cause some kind of toxicity, but rarely is it cancer.

"Large doses to animals artificially cause cancer. If you gave them smaller doses, they wouldn't get

cancer."

Would we be worried if one-tenth of one percent of the 100 million people who swallow a food additive got cancer from it? Sure, since that would be 100,000 extra cases of cancer. Well, if we wanted to give animals the human dose of the chemical to see if *they* would get cancer, and if we used the standard 50 animals for the test, we would theoretically expect that only one-tenth of one percent of the 50 rats would get cancer, even if the chemical were actually a carcinogen. One-tenth of one percent of 50 rats is one-twentieth of a rat! Put another way, if we did this experiment 20 times at the human dose, only once – on the average – would a single rat get cancer. The other 19 times, none of the 50 rats would get the disease. This kind of experiment – even if done with chemicals known to cause cancer in *humans*, such as estrogens or benzidine (a starter for dyes) – would yield a dangerous *false negative result*. In other words, too few animals are used to detect cases of cancer at so low a dose. Since it is not practical to test hundreds of thousands of rats, larger doses of the suspect chemical are used instead; with 200 times the human dose, we might expect to see ten or more rats out of 50 get cancer if the chemical is a true carcinogen.

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CONSUMER PRODUCTS *cont.*

Name of Product; Problem; Manufacturer and Contact Information

Tire Inflator and Hand Pumps. The Combination Tire Inflator and Hand Pumps can shatter under pressure when inflating tires if there is a blockage in the tire valve, posing the risk of bruises, lacerations, and ringing in the ears to consumers. Innovations In Cycling Inc., (800) 340-1050 or www.genuineinnovations.com.

Toy BBQ Grill. The circular ash tray attached to the stainless steel legs of the Play Wonder Toy Barbeque Grills could contain sharp edges, posing a laceration hazard. Target, (800) 440-0680 or www.target.com.

Toy Plastic Castles. The plastic rod can come loose allowing the colored counting beads to slide off of the Shape Sorting Toy Castles, posing a choking hazard to young children. Infantino LLC, (888) 808-3111 or service.infantino.com.

Treestands. The locking pins in the Treestands can come out unexpectedly, exposing consumers to possible injury due to a fall. TSR Inc., 888-656-2606 or www.olmanoutdoors.com.

VICTIM BEWARE, from page 8
Even if large doses cause cancer,
low doses – particularly when
you get below a certain threshold
– are safe.”

Unfortunately, this statement isn't true, either. Offering the best evidence of its inaccuracy are asbestos, radiation, and estrogens. Originally it was thought that asbestos and radiation caused cancer in humans only if they were exposed to large doses. Lower doses were thought to be "safe." Over the years, the allowable exposure levels for both have dropped steadily and repeatedly as the level thought to be safe one year was found to be associated with cancer the next. Similarly, estrogens, long thought to cause cancer only in large doses and only in animals, have been proven to cause cancer when given in small doses to women. Most independent scientists now agree that there is no evidence to support the concept of *any* safe level of a carcinogen.

Most people have been shoved into a typically corporate corner. Persuaded by advertising or custom, they believe they have no options other than obesity or saccharin, poverty or a dangerous job, cockroaches or carcinogenic pesticides, a miserable menopause or estrogens. Too many people feel the only way out of these choices is to deny the risks of products.

Blind denial is thus one ideological response to the fear of cancer. It may be psychologically soothing, but it is the ultimate cop-out to the corporate interests that sell us on these products. After all, the real goal of advertising is to accentuate the positive, eliminate the negative. Denying the risks of disease plays right into the corporate coffers.

A second ideological response to the cancer crisis marches under a banner called "Freedom of Choice." Why ban things? Just give us the information and we'll decide for ourselves. Free enterprise, the American way, in short is a glorification of personal choice that is as self-deceptive as the outright denial

of risks. When people choose to smoke, eat saccharin, etc., they are choosing – through health insurance, Medicare and other collective tax-supported programs – to make others (who don't smoke or swallow saccharin) pay for the costs of their diseases. If their choice is based on unacceptable alternatives (estrogens or a miserable menopause, job-caused cancer or poverty), there isn't really any choice at all. And when \$500 million is spent annually by industry to push the benefits of smoking, and less than \$5 million a year by government to inform people of smoking's risks, free choice is not allowed to flourish.

And now we come to "Blame the Victim." This is fashionable. As a cancer ideology it suffers from some of the same delusions as "free choice." To be sure, individuals, at an individual level, can and should develop plans and behaviors for protecting themselves and their families. But blaming the victim misses the whole corporate origin of cancer. It is a diversion from solutions that force the corporations to change. And it can be overwhelming to the victim. This third ideology is gaining popularity among those who believe that corporations are basically okay – they want to protect their customers' best interests as well as turn a profit, since healthy customers are buying customers – and that it is only the foolish individual who goes astray. One example of "blame the victim" ideology is the focus on the role of smoking in cancer among asbestos workers. There is no doubt that smoking increases the already alarming risk of lung cancer to which asbestos exposes these workers. But other asbestos-caused cancers, such as mesothelioma, occur in smokers and nonsmokers alike. The corporate decision? Clean up most, but not all the asbestos! (a little is safe, right?) Then refuse to hire smokers.

Worse is a current form of victim-blaming that corporate management tries to sell its workers. Instead of adequately reducing or eliminating

excessive noise or exposure to deadly carcinogenic chemicals at their source, management tells workers to wear hearing protectors or respirators or other kinds of so-called "protective" equipment. Recent studies by the National Institute of Occupational Safety and Health (part of the Department of Health, Education and Welfare [now HHS]) have shown that much of this equipment is not really effective in protecting workers because it is poorly constructed or fits badly. Yet the companies find this approach much less *costly* than the engineering of effective controls and, in this spirit, they blame the victim. Cancer is never the companies' fault.

The most hope for solving the cancer crisis comes from the ideology of collective action. This is the real alternative to getting cancer, and it may be the only one.

Three groups, organized to varying degrees, are leading this movement: progressive labor unions, such as the Oil, Chemical and Atomic Workers' Union [now part of PACE], organizing against workplace-caused cancer; women's health groups and groups such as Public Citizen, working against doctor- and drug company-induced cancer; and housewives (and househusbands) trying to stop food-induced cancer. Common to these cancer-fighting groups is the emergence of consumers as a force contending with producers and, we can hope, beginning to show strength. (Workers who consume carcinogens on the job are, in the producer/consumer dichotomy, consumers.)

As Adam Smith said centuries ago, the ultimate purpose of production is consumption. If producers don't bend to the wishes, needs and best interests of consumers, they will ultimately be broken. Like earlier waves of plague and infectious diseases, cancer will not be cured by surgery, radiation treatment, or drugs alone. It will abate only if it is prevented. And its prevention is not a medical decision; it is a political strategy. ■

Taming Technology: Resurrecting a Dismantled Agency

Health care in the United States is caught in a self-reinforcing cycle of escalating costs, unaffordable care, rising numbers of uninsured, and greater reliance on late and intensive care, which in turn propels the inflationary spiral. The result is that calls for universal health coverage on the part of several of the leading Democratic presidential candidates are accompanied by measures aimed at getting a handle on costs. To wit, the following quotes:

Hillary Clinton: "Building a national consensus around ... cost savings is a crucial step to cover all Americans with quality, affordable health care."

John Edwards: "The idea is to cover everybody, bring down health care costs for every single American, and ... fill in the cracks in our health care system."

Barak Obama: "In the end, coverage without cost controls will only shift our burdens, not relieve them."

Aware that rising costs are being driven by expensive care of dubious efficacy, all three candidates have called for the creation of a national institute to examine which services actually work. The expectation is that this would inform decisions on medical coverage and payment, and that the health plan would pay only for those treatments, drugs, or devices found to be effective. The logic behind this is so clear that the obvious question is: why has this not been done before?

The short answer: It has. Between 1972 and 1995 the nation had an Office of Technology Assessment (OTA) whose mandate was to "provide early indications of the probable beneficial and adverse impacts of the applications of technology." Reporting to Congress, the agency was designed to give the

legislative branch the tools it needed for the independent evaluation of national policy in a wide number of areas, including health, agriculture, transportation, energy, and the environment, among others. Once enacted, OTA's mandate broadened and became increasingly problem-oriented. Its agenda was driven by Congressional priorities, its reports clearly reflecting the issues that legislators were addressing at any given time.

The agency began operating in 1974 and quickly established itself as a valuable adjunct to the decision-making process. Each assessment included the convening of an advisory panel, an in-house research team, workshops with experts and stakeholders, extensive peer review of drafts, and delivery of reports through congressional hearings, briefings, and public release. Models of clear thinking and clean writing, OTA

"Through a comedy of errors, oversight, and political machismo, Congress [chose] ignorance and ended the 23-year history of its best and smallest agency."

— M. Granger Morgan

reports gathered, summarized, and translated technical issues in ways that were intelligible to the public. Because of the political environment in which it operated, OTA did not draw conclusions; rather, it presented the facts, distilled problems and alternatives, and discussed the pros and cons of different courses of action. OTA reports thus helped frame issues so that debates

could proceed from a consistent knowledge base and set of facts. The agency therefore earned high marks from the press. The *Washington Post* characterized it as "a dispassionate, nonpartisan player in the legislative process." The *Washington Times* described it as "the voice of authority in a city inundated with statistics and technical gobbledygook."

While health was only a fraction of its complete portfolio, the agency tackled a number of technological issues related to the efficacy of services and the well-being of the citizenry. These ranged from artificial insemination to wheelchairs, and included cost-benefit analyses of cholesterol screening, risks and benefits of artificial hearts, and the effectiveness of AIDS prevention strategies, among many others. The result was a vast literature that addressed many aspects of health care and created both more informed policy-makers and a more aware public.

The OTA's usefulness, however, did not insure its survival. While it had some important allies in Congress and had gained an international reputation, OTA was ultimately trampled in a "political stampede on the Hill to downsize and streamline." Its relatively small size, which made it efficient and nimble, facilitated its downfall. In addition, some of OTA's key supporters failed to show up or file proxies when the agency's continuation was at stake. In the words of M. Granger Morgan, professor and head of the Department of Engineering and Public Policy at Carnegie Mellon, "Through a comedy of errors, oversight, and political machismo, Congress [chose] ignorance and ended the 23-year history of its best and smallest agency."

Given this not-so-ancient history, the presidential candidates have a definite model to build on. OTA's analytical capabilities, modus operandi, and significant legacy are all worth recapturing if technology assessment is once again to be part of the craft of health care policy-making. ■

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- 45 million uninsured and at least another 55 million underinsured, about 1/3 of the population without adequate insurance
- 1.8 million American veterans without health insurance or access to the VA health system (Support our troops??)
- Medical bankruptcy, caused by inadequate health insurance, being one of the most common causes of personal bankruptcy
- The only country with most care

Common to all presidential "plans" to solve this problem - except for that of Representative Kucinich - is the retention of the major cause of the problem, the health insurance industry.

delivered by or through for-profit entities such as insurance companies, HMOs, nursing homes, and dialysis centers

- Annual excess administrative costs/waste of more than \$350 billion a year because of multiple payers
- A system that employs tens of thousands of people to specialize in denying care (non-health care professional private sector bureaucrats)

Common to all presidential "plans" to solve this problem - except for that of Representative Kucinich - is the retention of the major cause of the problem, the health insurance industry. A single-payer system eliminates these middle men and uses the freed-up funds to provide health care and, as articulated by the Labor Party, Just Health Care. ■

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