

# Health Letter

SIDNEY M. WOLFE, M.D., EDITOR

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## Study Shows National Health Insurance Could Save \$286 Billion on Health Care Paperwork:

Authors Say Medicare Drug Bill Will Increase Bureaucratic Costs, Reward Insurers and the AARP

A study by researchers at Harvard Medical School and Public Citizen published in the January issue of the *International Journal of Health Services* finds that health care bureaucracy last year cost the United States \$399.4 billion. The study estimates that national health insurance (NHI) could save at least \$286 billion annually on paperwork, enough to cover all of the uninsured and to provide full prescription drug coverage for everyone in the United States.

The study was based on the most comprehensive analysis to date of health administration spending, including data on the administrative costs of health insurers, employers' health benefit programs, hospitals, nursing homes, home care agencies, physicians and other practitioners in the United States and Canada. The authors found that bureaucracy accounts for at least 31 percent of total U.S. health spending compared to 16.7 percent in Canada. They also found that administration has grown far faster in the United States than in Canada.

The potential administrative savings of \$286 billion annually under national health insurance could:

1. Offset the cost of covering the

uninsured (estimated at \$80 billion)  
 2. Cover all out-of-pocket prescription drugs costs for seniors as well as those under 65 (estimated at \$53 billion in 2003).  
 3. Fund retraining and job placement programs for insurance workers and others who would lose their jobs under NHI (estimated at \$20 billion).  
 4. Make substantial improvements in coverage and quality of care for U.S. consumers who already have insurance.

Looked at another way, the potential administrative savings are equivalent to \$6,940 for each of the 41.2 million people uninsured in 2001 (the most recent figure available for the uninsured at the time study was carried out), more than enough to

pay for health coverage. The study found wide variation among states in the potential administrative savings available per uninsured resident. Texas, with 4.96 million uninsured (nearly one in four Texans), could save a total of \$19.5 billion a year on administration under NHI, which would make available \$3,925 per uninsured resident per year. Massachusetts, which has very high per capita health administrative spending and a relatively low rate of uninsurance, could save a total of \$8.6 billion a year, which would make available \$16,453 per uninsured person. California, with 6.7 million uninsured, could save a total of \$33.7 billion a year, which would make available \$5,016 per uninsured

*continued on page 2*

### CONTENTS

#### *Product Recalls*

**December 15, 2003-January 15, 2004**

The holidays brought their share of dangerous products.....4

#### *Canada Outdoes U.S. on Flu Vaccine Policy*

We have lessons to learn from north of the border.....7

#### *How to Achieve Positive Results Without Actually Lying*

Just because it's a spoof, doesn't mean it isn't true .....9

#### *Outrage of the Month*

AARP socks it to seniors and it isn't pretty .....12

**STUDY, from page 1**

person. (See accompanying chart for details on other states.)

Last week, the government reported that health spending accounts for a record 15 percent of the nation's economy and that health care spending shot up by 9.3 percent in 2002. Insurance overhead (one component of administrative costs) rose by a whopping 16.8 percent in 2002, after a 12.5 percent increase in 2001, making it the fastest growing component of health expenditure over the past three years. Hence the figures in the Harvard/Public Citizen Report (which was completed before release of these latest government figures), may underestimate true administrative costs.

The authors of the *International Journal of Health Services* study attributed the high U.S. administrative costs to three factors. First, private insurers have high overhead in both nations but play a much bigger role in the United States. Second, The United States' fragmented payment system drives up administrative costs for doctors and hospitals, who must deal with hundreds of different insurance plans (for example, at least 755 in Seattle alone), each with different coverage and payment rules, referral networks, etc. In Canada, doctors bill a single insurance plan, using a single simple form, and hospitals receive a lump sum budget, much as a fire department is paid in the United States. Finally, the increasing business orientation of U.S. hospitals and insurers has expanded bureaucracy.

The Medicare drug bill that Congress passed last month will only increase bureaucratic spending because it will funnel large amounts of public money through private insurance plans with high overhead.

"The recent Medicare bill means a huge increase in administrative waste and a big payoff for the AARP," said study author Dr. David Himmelstein, an associate professor of medicine at Harvard and former staff physician at Public Citizen's Health Research Group. "At present, Medicare's overhead is less than 4 percent. But all of the new Medicare money — \$400

billion — will flow through private insurance plans whose overhead averages 12 percent. So insurance companies will gain \$36 billion from this bill. And the AARP stands to make billions from the 4 percent cut it receives from the policies sold to its members."

Dr. Steffie Woolhandler, a study author, associate professor of medicine at Harvard and a founder of Physicians for a National Health Program said, "Hundreds of billions are squandered each year on health care bureaucracy, more than enough to cover all of the uninsured, pay for



*U.S. consumers spend almost twice as much per capita on health care as Canadians who have universal coverage and live two years longer.*



full drug coverage for seniors and upgrade coverage for the tens of millions who are underinsured. U.S. consumers spend almost twice as much per capita on health care as Canadians who have universal coverage and live two years longer. The administrative savings of national health insurance make universal coverage affordable."

Dr. Sidney Wolfe, director of Public Citizen's Health Research Group added: "This study, documents the state-by-state potential administrative savings achievable with national health insurance. These enormous sums could be used to provide health care for the more than 43 million uninsured people in the United States and drug coverage for seniors. These data should awaken governors and legislators to a fiscally sound and

humane way to deal with ballooning budget deficits. Instead of cutting Medicaid and other vital services, officials could expand services by freeing up the \$286 billion a year wasted on administrative expenses. In the current economic climate, with unemployment rising, we can ill afford massive waste in health care. Radical surgery to cure our failing health insurance system is sorely needed."

Dr. Himmelstein described the real-world meaning of the difference in administration between the United States and Canada by comparing hospitals in the two nations. Several years ago, he visited Toronto General Hospital, a 900-bed tertiary care center that offered an extensive array of high-tech procedures, and searched for the billing office. It was hard to find, though; it consisted of a handful of people in the basement whose main job was to send bills to U.S. patients who had come across the border. Canadian hospitals do not bill individual patients for their care and so have no need to keep track of who receives each Band-Aid or an aspirin.

"A Canadian hospital negotiates its annual budget with the provincial health plan and receives a single check each month to cover virtually all of its expenses," Himmelstein said. "It need not fight with hundreds of insurance plans about whether each day in the hospital was necessary, and each pill justified. The result is massive savings on hospital billing and bureaucracy."

Doctors in Canada face a similarly simple billing system. Every patient has the same insurance. There is one simple billing form with a few boxes on it. Doctors check the box indicating what kind of visit they provided to the patient (i.e., how long and whether any special procedures were performed) and send all bills to one agency.

Himmelstein returned to Boston and visited Massachusetts General Hospital, which was similar to Toronto General in size and in the range of services provided. Himmelstein was told that Massachusetts General's

billing department employed 352 full-time personnel, not because the hospital was inefficient, but because this department needed to document in detail every item used for each patient and fight with hundreds of insurance plans about payment.

“U.S. doctors face a similar billing nightmare,” Himmelstein said. “They deal with hundreds of plans, each with different rules and regulations,

each allowing physicians to prescribe a different group of medications, each dictating that doctors refer patients to different specialists.

“The U.S. system is a paperwork nightmare for doctors and patients, and wastes hundreds of billions of dollars.”

###

Dr. Woolhandler and Dr. Himmelstein are co-founders of

Physicians for a National Health Program, an organization with over 12,000 members advocating for single-payer national health insurance in the United States. PNHP was founded in 1987 and has physician spokespeople across the country. For a local spokesperson, call the national headquarters at 312-782-6006. Visit them online at [www.pnhp.org](http://www.pnhp.org).

**Table 1**  
**Potential administrative savings by state, 2003,**  
**achievable with a Canadian-style national health insurance program**

	<b>Projected 2003 health expenditures, current system \$ millions</b>	<b>Administrative expenses in 2003, \$ millions</b>	<b>Potential administrative savings in 2003, \$ millions</b>	<b>Uninsured residents in 2001, thousands</b>	<b>Administrative savings per uninsured resident, \$</b>
<b>United States</b>	<b>1,660,500</b>	<b>399,356</b>	<b>285,961</b>	<b>41,206</b>	<b>6,940</b>
Connecticut	22,144	5,97	4,225	346	12,212
Maine	7,068	1,884	1,325	132	10,037
Massachusetts	43,603	12,090	8,556	520	16,453
New Hampshire	6,656	1,773	1,277	119	10,733
Rhode Island	6,353	1,672	1,174	80	14,677
Vermont	2,963	774	552	58	9,513
Delaware	4,433	1,186	837	73	11,468
District of Columbia	6,226	1,816	1,244	70	17,771
Maryland	28,166	7,647	5,509	653	8,437
New Jersey	47,320	12,625	9,030	1,109	8,143
New York	122,958	33,664	23,437	2,916	8,037
Pennsylvania	73,293	19,932	14,053	1,119	12,559
Illinois	63,778	17,389	12,339	1,676	7,362
Indiana	30,641	8,367	5,902	714	8,266
Michigan	50,907	13,591	9,638	1,028	9,375
Ohio	60,353	16,530	11,644	1,248	9,330
Wisconsin	28,598	7,727	5,527	409	13,513
Iowa	14,716	3,978	2,777	216	12,857
Kansas	13,441	3,610	2,562	301	8,511
Minnesota	28,862	7,885	5,793	392	14,777
Missouri	30,539	8,440	5,931	565	10,498
Nebraska	8,821	2,362	1,637	160	10,233
North Dakota	3,854	1,073	745	60	12,415
South Dakota	4,005	1,104	780	69	11,305
Alabama	22,541	6,205	4,459	573	7,781
Arkansas	12,319	3,341	2,360	428	5,515
Florida	87,077	23,578	17,071	2,856	5,977
Georgia	39,293	10,765	7,805	1,376	5,672
Kentucky	20,895	5,718	4,042	492	8,216
Louisiana	23,729	6,622	4,680	845	5,538
Mississippi	13,044	3,609	2,537	459	5,527
North Carolina	38,773	10,552	7,472	1,167	6,403
South Carolina	18,780	5,057	3,569	493	7,240
Tennessee	31,474	8,690	6,256	640	9,775
Virginia	31,994	8,566	6,130	774	7,920
West Virginia	10,129	2,743	1,939	234	8,286

*continued on page 4*

**Table 1**  
**Potential administrative savings by state, 2003,**  
**achievable with a Canadian-style national health insurance program**

*continued from page 3*

	Projected 2003 health expenditures, current system \$ millions	Administrative expenses in 2003, \$ millions	Potential administrative savings in 2003, \$ millions	Uninsured residents in 2001, thousands	Administrative savings per uninsured resident, \$
Arizona	21,673	5,848	4,296	950	4,522
New Mexico	7,745	2,108	1,500	373	4,022
Oklahoma	15,734	4,273	3,038	620	7,899
Texas	98,742	27,082	19,469	4,960	3,925
Colorado	19,568	5,231	3,802	687	5,534
Idaho	4,937	1,289	919	210	4,378
Montana	4,122	1,115	784	121	6,477
Utah	8,567	2,241	1,607	335	4,798
Wyoming	2,019	534	376	78	4,814
Alaska	3,011	787	565	100	5,650
California	162,943	45,041	33,699	6,718	5,016
Hawaii	6,612	1,798	1,325	117	11,321
Nevada	8,058	2,134	1,577	344	4,585
Oregon	15,811	4,069	2,938	443	6,631
Washington	27,912	7,265	5,254	780	6,735

## Product Recalls

*December 15, 2003 — January 15, 2004*

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.

### D R U G S   A N D   D I E T A R Y   S U P P L E M E N T S

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. A Class I recall is a situation in which there is a probability that the use of or exposure to the product will cause serious adverse health consequences or death. Class II recalls may cause temporary or medically reversible adverse health consequences. A Class III situation is not likely to cause adverse health effects. 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](http://www.fda.gov).

*Name of Drug or Supplement; Class of Recall; Problem*

**Bactroban Nasal Ointment** (Mupirocin Calcium Ointment 2%), 1.0 gram Single-Use Tubes, Rx Only; Class III; Superpotent; Stability (6 month)

**Cold & Hot Therapy Pain Relief Cream**, Extra Strength (Methyl Salicylate 30% and Menthol 10%) Net Weight 1.25 oz. (35.4g). Sold under other brands as: 1) Brooks Pharmacy Cold and Hot Extra Strength Therapy Pain Relief Cream, Net Weight 1.25 oz. (35.4g); 2) Pathmark Extra Strength Cold and Hot Therapy Pain Relief Cream, Net Weight 1.25 oz. (35.4g); 3) Extra Strength Cold & Hot pain relief cream, Net Wt. 3 oz. (85 g); Class III; Subpotent; (Methyl Salicylate) 12-month stability

*Lot #: Quantity and Distribution; Manufacturer*

Lot No. SKAK; Exp. 10/04; 12,500 cartons (10 tubes/carton) distributed nationwide; GlaxoSmithKline; Zebulon, NC

Numerous lots; 11,868 (1.25-oz.) & 35,724 (3-oz.) tubes distributed nationwide; Qualis Inc.; Des Moines, IA

## M E D I C A L   D E V I C E S

Device recalls are classified in a manner similar to drugs: Class I, II or III, depending on the seriousness of the risk presented by leaving the device on the market. Contact the company for more information. You can also call the FDA's Device Recall and Notification Office at (301) 443-4190. To report a problem with a medical device, call (800) FDA-1088. The FDA web site is [www.fda.gov](http://www.fda.gov).

### *Name of Device; Class of Recall; Problem*

**Invacare IVC Home Care Bed** (Foot Section with new head actuator from Linak); Class II; Pull tube on bed may bend or separate causing inoperability of bed or head section to fall

### *Lot #: Quantity and Distribution; Manufacturer*

Numerous lots; 5,926 distributed nationwide and in Canada; Invacare Corporation; Elyria, OH

## C O N S U M E R   P R O D U C T S

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](http://www.cpsc.gov).

### *Name of Product; Problem*

**Bumble Bee Toys.** The blue antennae on the Bumble Bee toy can break, posing a choking hazard to young children.

### *Lot #: Quantity and Distribution; Manufacturer*

Bumble Bee Toys with blue antennae sold with certain Graco high chairs and Graco mobile entertainers, and also sold separately as an accessory and replacement part; about 398,000 sold nationwide from October 2001 through March 2003; Graco Children's Products, Inc.; Exton, PA; (800) 258-3213

**Christmas Sweaters with Feather Trim.** The marabou feather trim on the sweaters is dangerously flammable.

Ladies' Christmas sweaters with marabou feather trim; 1,100 sold nationwide from November 2002 through January 2003; Susan Bristol Inc., of Boston, MS; (800) 537-4309

**Compact Utility Tractors.** An internal failure may occur within the Hydrostatic Transmission preventing the transmission from returning to neutral after the pedals are released. This can allow unexpected movement or cause the tractor to continue moving, creating a possible risk of injury to the operator or a bystander.

John Deere 4000 Ten Series Compact Utility Tractors; 1,700 sold nationwide and in Canada from April 2001 through August 2003; Deere & Company; Moline, IL; (800) 537-8233; [www.johndeere.com](http://www.johndeere.com)

**CROWNZZ(tm) Candleholders.** The candleholders do not allow for the safe burning of a candle, which poses a fire hazard to consumers.

The Christmas-themed candleholders were sold in various shapes and sizes, and include the following model names and numbers: Snowman (79911), Scarecrow (79914), Santa (79917), Swan (79912), Angel (79913), Rose (79915), Girl (79918) and Kneeling Angel (79916); 2,300 sold nationwide between November 2003 and December 2003; Mr. Christmas Inc.; New York, NY; (800) 467-9627

**Extension Cords.** Use of these extension cords could result in an electric shock or electrocution to consumers.

Durex Procraft Outdoor Extension Cords; 60,000 sold nationwide from June 2003 through November 2003; Family Dollar Services, Inc.; Charlotte, NC; (800) 682-0097

**Hanukkah Menorahs.** The acrylic base of the Hanukkah menorah can ignite if the candles are allowed to burn completely, creating a fire hazard.

Crate and Barrel Hanukkah Menorah; 800 sold in Crate and Barrel stores and online nationwide from October 2003 through December 18, 2003; Crate and Barrel; Northbrook, IL; (800) 323-5461; [www.crateandbarrel.com](http://www.crateandbarrel.com)

*continued on page 6*

*Name of Product; Problem*

**Holiday Candle Gift Sets.** Paint on the exterior surface of the candles could potentially sustain flame posing a potential fire hazard.

**Jack-In-the-Box Toys.** A spring mechanism attached to the lid can break and detach from the toy, posing a choking hazard to young children.

**"Lily Pad Clacker" Instruments.** The green coating on the Lily Pad Clacker instruments contain high levels of lead, posing a risk of poisoning to young children.

**Lighting Fixtures.** The lamp can fall out of the lamp socket and strike somebody standing or walking beneath the light fixture, posing a laceration risk if the lamp breaks.

**Rocking Chairs.** The chairs' support assembly can fail and cause the rocking chair to collapse, posing the risk of injury to the user.

**Thematic Candles.** Resin in the candleholder can ignite, posing a serious burn and fire hazard to consumers.

**Tree Stands for Hunters.** A serrated blade that supports the stand on a tree can bend, posing the risk of falls and serious injuries to hunters.

**Wet/Dry Vacuums.** The exhaust blower ports on the wet/dry vacuums are large enough for a small child to reach inside and touch the spinning blower wheel. This poses a laceration hazard to small children.

*Lot #; Quantity and Distribution; Manufacturer*

The "Painted Snowman" gift set includes three candles, a display plate, pine sprigs, and golden berries. 10,085 units sold at Wal-Mart stores nationwide from September 2003 through December 2003; Wal-Mart, Bentonville, AR; (800) 925-6278

The Jack-In-the-Box toy is battery operated, and has two yellow sides, two red sides, and a blue top and bottom. "THE LEARNING JOURNEY" is printed on the bottom of the toy. 56,000 sold nationwide from August 2003 through November 2003; The Learning Journey International, L.L.C.; Phoenix, AZ; (800) 445-AVON

Designed for use with the Frog Went A-Dancing music kit; 430 sold by Do-Re-Me & You! consultants in North Carolina, South Carolina, Georgia, Virginia and Texas from October 2003 through December 2003; Kindermusik International; Browns Summit, NC; (800) 628-5687; [www.drmy.com](http://www.drmy.com)

Enviroguard 22 Inch Diameter Low Mount Open Lighting Fixture; 1,850 sold nationwide from January 1999 through October 2003; Guth Lighting (division of JJI Lighting Group; St. Louis, MO; (314) 533-3200

Model nos. P155131 and P155132; 2,900 sold nationwide from January 1997 through May 2003; Hill-Rom, a Hillenbrand Industry; Batesville, IN; (800) 445-3720

57 different models and themes, including a birdhouse design, watering can, flowerpot, and Halloween and Christmas designs; between 1 1/2 to 4 inches in height and 2 1/2 to 3 inches in width; 92,000 sold nationwide from September 2001 through May 2003; Lang Candles, Delafield, WI; (888) 526-4011; [www.lang.com](http://www.lang.com)

Original Ol' Man Double X with model number OMDX-MO, Grand Ol' Man Double X model number GOMDX-MO, Multi-Vision model number MV-MO, and Grand Multi-Vision Model number GMV-MO; 1,775 sold nationwide from June 2003 through November 2003; Ol' Man Treestands; Hattiesburg, MS; (800) 861-7595; [www.olmantreestands.com](http://www.olmantreestands.com)

Craftsman 16-gallon and RIDGID 12- and 16-gallon wet/dry vacuums; sold at Home Depot stores and RIDGE Tool distributors nationwide from March 1999 through October 2002 and Sears Roebuck & Co. stores nationwide from September 1998 through October 2002; Emerson Tool Company, a division of Emerson Electric Co.; St. Louis, MO; (800) 359-0179; [www.wetdryvacrecall.com](http://www.wetdryvacrecall.com)

# Canada Outdoes the U.S. on Flu Vaccine Policy

We have all seen pictures on the news of people waiting in long lines to get their flu shots this year; many of us were not able to get one before the supply ran out. Because the Canadians have taught us a thing or two about how to run a national health insurance system, we decided to look to our neighbors north of the border to see how they handle their flu shots. We found that the Canadian government, particularly the Ontario Ministry of Health, has implemented innovative strategies to ensure that its residents are protected from the flu, and we would do well to learn from their example. We pay three times as much for each shot and vaccinate a much lower percentage of our high-risk population.

Influenza viruses cause annual winter epidemics leading to an estimated 36,000 deaths in the United States each year. Annually, influenza is also responsible for hundreds of thousands of hospitalizations, tens of millions of workdays lost, and costs the U.S. economy tens to hundreds of billions of dollars.

Simple hand-washing and covering your mouth when you cough or sneeze can limit spread of the disease, but the disease can also be prevented by two different vaccines. One is a shot, the inactivated vaccine. The other, available this year for the first time, is squirted into the nostrils and is a live vaccine. They are both about 70% effective and both must be given every year because immunity wanes quickly and the virus changes over time. Both vaccines have the same viruses in them, and the composition of each year's vaccine is based on the published recommendations of the World Health Organization's Global Influenza Surveillance Network. The nasal vaccine can only be given to healthy people between the ages of 5 and 49 and can't be given to pregnant women, while the shot can be given to almost anyone over 6 months old.

Vaccination is "strongly recommended" by the U.S. Advisory Committee on Immunization Practices (ACIP) for everyone who is considered high-risk for influenza-related complications or death. High-risk people include those 65 years of age or older, in nursing homes, or with heart or lung diseases like asthma, kidney diseases, problems with their immune systems, blood problems like sickle cell disease, diabetes, and pregnant women. People who could give high-risk people the flu, like their household contacts and health care workers, are also "strongly recommended" to get the vaccine. A flu shot is also available and encouraged by ACIP for anyone else who wants it.

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In the United States, the influenza vaccine supply is produced completely by private manufacturers who independently determine the amount of vaccine produced each year based on demand during the previous flu season. For five years prior to this flu season, there has been an overproduction of vaccine, resulting in doses being discarded and money lost to manufacturers. Last year, 95 million doses were made and 12 million discarded, so only 83 million doses were manufactured this year. The media also portrayed this season as

especially severe, when in actuality it simply started earlier and has already peaked in many places. We also don't know if more children died this year from the flu because we simply don't have accurate numbers from past years. The misperception of a particularly bad flu season led to increased demand for the vaccine, which — combined with manufacturers making fewer doses — resulted in the current shortage of influenza vaccine. Predictably, manufacturers and distributors exploited the situation by raising their prices. Health departments usually pay about \$8 wholesale per shot, but as the season progressed and supplies dwindled, some states, such as Georgia and Colorado, were paying \$16.50 per shot.

Even without these problems, vaccination coverage rates have been dismal historically. There are approximately 185 million people in the United States who fall into the "strongly recommended" group, but only 70-75 million people are vaccinated each year, including people who are not high-risk. That's a total of one-fourth of the roughly 292 million people in the U.S. The highest coverage is among the elderly, with 64% of people 65 or older receiving vaccinations in the winter of 2000-2001, and 83% of people in nursing homes vaccinated in 1998. There is considerable racial disparity, however, with 70% of white people 65 or older vaccinated in 2001-2002, but only 52% of non-Hispanic African Americans and 47% of Hispanics vaccinated. Younger people in high-risk groups fare even worse, with 29% of high-risk 18-64 year olds and only 10-25% of pediatric asthmatics vaccinated. Clearly, we are not adequately reaching the high-risk people, and with the decentralized system in place in the U.S., it is difficult to redistribute vaccines appropriately. This year, low-risk people were the recipients of a large enough number of vaccinations that we ran out of vaccines

*continued on page 8*

**FLU VACCINE, from page 7**

before some high-risk people could get their shots.

The situation in Canada is considerably different. It has a National Health Insurance program that covers everyone in the country and enables the country to act as a large buying unit. The vaccine is purchased by the federal government for a negotiated price, which is \$2.68 per dose in U.S. dollars this year, or one-third what U.S. health departments usually pay. Unfortunately, the recently passed Medicare drug reform in the U.S. specifically prohibits negotiating drug prices. The amount of vaccine purchased in Canada is based on requests from the provinces, and was 10.4 million doses this year. The government is not concerned about over-ordering since the manufacturers have agreed to take back for credit up to 5% of their product, if necessary. The vaccines are then distributed to the provincial governments, who mount impressive media campaigns about flu shots, including TV and radio ads, posters on public transportation, information in workplaces, and hotlines to find the nearest clinic. The provinces also have centralized redistribution systems to handle local shortages if necessary. This year in the U.S., there were areas that had completely run out of vaccine but still had unvaccinated high-risk people, while other places had extra vaccine left over. In Canada, the extra vaccine could have been moved easily to areas of short-

age, but in the U.S. we have no way of redistributing those shots, or even knowing where they are.

One Canadian province, Ontario, has gone still further. Rather than just targeting high-risk populations, it concluded that the greatest public health benefit would be derived from vaccinating everyone without contraindications because many high-risk people contract the flu from low-risk people. Therefore, for the past four years, the province has offered free influenza vaccination to all residents over 6 months old. Based on previous years' experiences, it purchased about 6 million doses this year, enough to vaccinate 50% of the entire population. As of early January 2004, Ontario had already administered 5.5 million doses. Despite including low-risk people, the province is still remarkably successful at reaching their high-risk populations. Last year Ontario vaccinated 77% of people 65 or older (compared with 64% in the U.S.), 48% of people aged 16-65 with chronic medical conditions (29% in the U.S.), and 95% of people in long-term care facilities (83% in the U.S.). The program, including vaccine price and an intensive media campaign, is expected to cost 22.6 million U.S. dollars. The program seems here to stay as the Ministry of Health has committed to free universal influenza vaccination and approximately 80% of Ontario residents approve of the program.

Some steps are already being taken to improve flu vaccination in

the U.S., such as the expanded recommendation for routine flu shots for all children aged 6 to 23 months beginning next winter. In addition, Secretary Tommy Thompson of the Department of Health and Human Services has requested \$100 million from Congress in the 2004 budget to finance research to develop adequate influenza vaccine supply in case of a major outbreak. This money has not yet been appropriated, however, so it is unclear if the program will ever see the light of day. However, given the failures of the U.S. system, it is in our best interest to institute parts of the Ontario plan. Critical components of the Canadian policy that bear emulating include centralized price negotiation, purchasing, distribution, and redistribution if necessary. To reassure manufacturers, the government must guarantee to purchase a minimum number of vaccines. If our government could negotiate a price equivalent to the Canadians' (and because of our larger size we should actually do better), we could have bought three times the amount of vaccine we bought this year for the same amount of money, thus eliminating the shortage. The other lesson to be learned from Ontario is to conduct a massive media campaign targeting both the public and health care practitioners to decrease racial disparities and increase the coverage of our high-risk citizens and our population as a whole.

**Editor.....Sidney M. Wolfe, MD**  
**Managing Editor.....Lynn Miller**  
**Staff Researcher.....**  
*Sherri Shubin, MD, MPH*  
**Information Specialist.....John Paul Fawcett**  
**Production Mgr.....Kristy L. Jackson**  
  
**President.....Joan Claybrook**  
**Founder.....Ralph Nader**

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The Health Research Group was co-founded in 1971 by Ralph Nader and Sidney Wolfe in Washington, D.C. to fight for the public's health, and to give consumers more control over decisions that affect their health.

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# Harlot: How to Achieve positive Results without actually Lying to Overcome the Truth.

*The following is excerpted from an article by the editor of the British Medical Journal, Dr. Richard Smith, published recently in the Guardian in the United Kingdom.*

Drug companies spend hundreds of millions of pounds to bring a new drug to market, and tens of millions of pounds to do the clinical trials that are necessary for both registration and marketing. Understandably, they would prefer not to get results from these trials that are unfavourable to their drug. And, despite the ubiquitous uncertainties of science and medicine, they rarely do. How do they manage it?

In 1994, Canadian researchers looked at 69 trials of anti-arthritis drugs funded by drug companies and published in prominent medical journals. In every case the drug made by the company was as good as the comparative treatment, and in a quarter of the trials it was better. Not once did a company fund a trial that proved unfavourable to it.

A review published in 2003 found 30 studies that had compared the results of trials funded by drug companies with those funded from other sources. Trials funded by companies were four times more likely to have results favourable to them than those funded by others.

How then do companies usually manage to fund research that is favourable to them? An answer is supplied in a recent issue of the BMJ by Dave Sackett and Andy Oxman, two tireless campaigners for the better use of scientific evidence in medicine. They have founded a spoof company called Harlot — which stands for How to Achieve positive Results without actually Lying to Overcome the Truth.

Harlot plc promises to give drug companies and others the results they want. Your drug may be wholly inef-

fective, Sackett and Oxman promise, but as long as it isn't a lot worse than a sip of triple distilled water, then Harlot can produce positive results from a trial. Importantly, these results are not usually achieved by doing poor quality trials. The trick is in the question asked and the design of the trial. Sackett and Oxman, both experts on the design and analysis of trials, describe 13 methods for getting the results you want.

One of the commonest methods is to test a new drug not against an

*70% of trials in major medical journals are funded by the drug industry.*

effective treatment but against a placebo. Ironically, regulators often require companies to do this. But what matters to patients is not whether a company's drug is better than nothing, but whether it is better than established treatments. Companies are nervous about these "head-to-head" trials, particularly if many drugs are being tested — because there may be only one winner and many losers. A huge publicly funded head-to-head trial of treatments for high blood pressure was published recently and threw companies into a tizz because it showed that long-established drugs that are off patent were better than newer, much more expensive drugs.

A company gets huge benefit from showing that its drug is better than a competitor's. But the company needs to control the trial, and Harlot suggests that a company compares its

product with an inadequate dose of a competitor's product. This may have been the reason why previous trials on drugs for high blood pressure suggested that newer drugs were better.

A variant on this technique is to compare the drug with an excessive dose of the competitor's product: it is then possible to show that the company's drug has far fewer side-effects (because side-effects are more common with higher doses of a drug). This may have been the method for showing that new and expensive drugs for schizophrenia have fewer side-effects than older drugs.

Perhaps the most common method to avoid unfavourable results is to make sure that a trial is not big enough to show that a competitor product is either better or worse. Such trials are very common, and Silvio Garattini, a leading Italian researcher and critic of the drug industry, has proposed a consent form for them: "I understand that this trial is worthless for science and medicine, but will be of great use to the marketing department of Shangri-la Pharmaceuticals."

All this matters greatly because 70% of trials in major medical journals are funded by the drug industry. Often companies will buy reprints of these articles to use in promoting their drug. Sometimes they may spend up to £750,000.

Virtually all research on drugs is funded by the industry, because governments have taken the view that public money can be better spent elsewhere. The end result is that information on drugs (on which Britain spends £7bn a year) is distorted.

The Harlot article was written to amuse, but is as deadly serious as anything else published in the BMJ (British Medical Journal) in the past 10 years. The public is being regularly deceived and exploited.

## OUTRAGE, from page 12

I was appalled, but not surprised, to see that the AARP had taken approximately seven million dollars of their members' dues money to take full page ads in the *New York Times* and other publications to push legislation that would ultimately screw those selfsame members. After all, isn't the AARP primarily an insurance peddling outfit with a veneer of social service? In the '90s, hadn't they gone ballistic when their California members voted overwhelmingly to support proposition 187, which would have established a non-profit single-payer health insurance in California? And hadn't they done the same in a similar instance in Colorado? In 1994, *Smart Money* magazine ran a piece entitled "The AARP, Whose Side Are They On, Anyway?", but it evidently didn't get wide circulation.

My state of being appalled at the AARP ads turned into outrage when I received a letter from Bill Novelli, their Executive Director. Mr. Novelli, reminding me of a used car salesman on TV, attempted to tell me what a wonderful thing that AARP had accomplished. This, in collaboration with the most reactionary elements of the Republican party.

Novelli started off by saying that "...without the support of members like you, we could not have secured this historic change to Medicare." This is one of the few truthful statements in the entire letter, although the "historic change" is not the

change they would have us believe.

The real historic change, according to economist Dean Baker, is that the legislation changes the nature of the guarantee that Medicare provides to seniors. Currently all seniors are guaranteed that they will be able to purchase the traditional plan, but have the option to choose a private alternative, if they believe it provides better benefits. This guarantee would be eliminated in certain "test" markets under the bill, with seniors only guaranteed a voucher sufficient to purchase a private plan. They may be forced to pay several thousand dollars, if they choose to stay in the traditional plan. I was unable to find any mention of this major change to Medicare anywhere in Mr. Novelli's letter.

What I did find was this line in boldface type: AARP WOULD NEVER SUPPORT LEGISLATION THAT WOULD THREATEN TRADITIONAL MEDICARE. Really, Mr. Novelli? Haven't you done just that? Isn't that why 15,000 members, by your own admission, cancelled their memberships? He admits that what they considered most important was to get "SOMETHING" passed this year. "Going back to the drawing board would not serve the millions of our members who need help now." Hello, Mr. Novelli, the prescription drug benefit doesn't kick in until 2006.

Did you ever wonder why prescription drugs are cheaper in Canada? They are because the

Canadian government negotiates directly with the drug manufacturers and wields the weight of its tremendous buying power when negotiating. Again, Mr. Novelli didn't mention this in his letter, but this bill prohibits our government from doing just that for Medicare.

Mr. Novelli admits, "But the legislation is not perfect." That's like saying Saddam Hussein was slightly annoying.

This legislative poison pill, which the Congress, along with the drug manufacturers, the for-profit insurance companies, as well as the HMOs and the AARP, were encouraging us to swallow before bedtime, contains some pernicious sleepers, which all the usual suspects, along with most of the mainstream media, went to great lengths to obfuscate, if not conceal outright.

What is really most outrageous about this letter from AARP Executive Bill Novelli, is the attempt, along with the attempts of others, to conceal the true gist of this legislation, which is now codified into law, from the American people.

Many years ago we schoolboys used an inelegant expression to isolate those who attempted to deceive us in this manner: Stop peeing on my leg and telling me it's raining. The letter ends, "As always, AARP is committed to you."

*See article below for more on the AARP.*

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## AARP Rebellion Grows

*The following article was originally published in the February 1994 issue of Health Letter and is reprinted because of its relevance to our OUTRAGE OF THE MONTH.*

**W**e have previously reported (see *Health Letter*, June 1991) that the American Association of Retired Persons

(AARP) gets \$100 million a year from the Prudential insurance company — a sort of kickback — for exclusively allowing the company to market a variety of Prudential health insurance policies to AARP members. Thus, we have maintained, national AARP is "incapable" of advocating a single payer health care system, which would cut out this major source of

income to the organization.

Many state and local AARP chapters have begun to rebel at this numbers-be-damned stance of national AARP and we excerpt a recent example below — an editorial written by Dr. Bruce Douglas, President of the North Shore, Illinois chapter of AARP, Clinical Professor and Senior Fellow in

*continued on page 11*

AARP, from page 10

Aging and Applied Gerontology of the University of Health Sciences/Chicago Medical School, and Professor of Public Health at the University of Illinois.

### **The United States Needs a Single Payer Health Care System**

The time has come for AARP, the most powerful citizen lobbying group in Washington, to speak out loud and clear in favor of single payer health care reform in the United States. The 34 million members of AARP have been subjected to demeaning, condescending, and elusive tactics long enough by a paid Washington staff that has failed to convince the AARP membership that its ties to the insurance industry have prevented it from demonstrating objectivity in its responsibilities to its members and the American people.

Single payer is so blatantly superior to any other system that has been paraded before that American people, that it is in the words of The New Yorker magazine, "almost embarrassing" to have to "reassemble...the pile of evidence" that demonstrates that contention to be true.

This editorial is intended to serve as a rallying call to AARP volunteers everywhere to take over the leadership of the organization on the issue of health care reform and to demand that AARP open its eyes, ears, and heart to what is clearly best for the American people.

First, let it be said that "single payer" is intrinsically a free-choice system in which the private system of health care delivery is maintained. The patient has absolute control over his/her choice of health care provider.

Single payer is based on a simple

*"Single payer" is intrinsically a free-choice system...the patient has absolute control over his/her choice of health care provider.*

economic concept that the system can only spend as much money as it has. Planning for the provision of care under single payer is based on the amount of money that is available or obtainable, through taxation, and the restraints that are built into the system limit how much is paid to providers and others who make up the infrastructure of the care apparatus....

These are the principles AARP should stand for; and this is the position the Association should be taking as it advocates what is best for the American people.

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# AARP and Medicare Legislation

The following *OUTRAGE* was contributed by long-time Public Citizen supporter and former CBS news employee, Larry Racies of New York City.

The photo on the front page of the December *AARP Bulletin* shows a clenched fist with an upraised thumb behind a headline which screams, "What's In It For You," giving a "thumbs-up" to the recently passed Medicare drug benefit. A more realistic appraisal of what's really in it for you in this bait-and-switch legislation would have been more accurately portrayed by an upraised middle finger, because the finger is what the Republicans, with the help of 16 Democrats and the AARP, have given to America's seniors.

*continued on page 10*



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