



Published on *Physicians for a National Health Program* (<http://www.pnhp.org>)

# Oncologists Call for Single-Payer System

By **Charles Bankhead**

*MedPage Today, Jan. 29, 2014*

Oncologists have a "moral and ethical obligation" to their patients to advocate for a single-payer universal health insurance program, according to two oncologists who stated their case in an editorial.

A single-payer system would simplify healthcare delivery for patients and providers without sacrificing quality of care, said Ray Drasga, MD, and Lawrence Einhorn, MD, in an editorial published online in the *Journal of Oncology Practice*, a journal of the American Society of Clinical Oncology.

The switch to such a national system would face huge and innumerable challenges, but gradual implementation, perhaps even on a state-by-state basis, would reduce the administrative burdens, they wrote.

"Because the [Affordable Care Act or ACA] will fail to remedy the problems of the uninsured, the underinsured, rising costs, and growing corporate control over care giving, we cannot in good conscience stand by and remain silent," said Drasga, a retired oncologist in Chicago, and Einhorn, of Indiana University in Indianapolis.

"Life is short, especially for some patients with cancer; they need help now."

## Making Their Case

Drasga and Einhorn state their case for a single-payer system by delineating problems that such a system could address:

- Reduced administrative costs, which currently account for almost a third of healthcare expenditures
- Eliminating many bankruptcies attributable to healthcare costs, which accounted for more than 60% of family bankruptcies identified in a 2009 report
- Improved health, as indicated by evidence that being uninsured increases the mortality hazard by 40%
- Building on an existing structure, noting that about 60% of all healthcare in the U.S. is publicly funded

- Implementation of proven cost-containment strategies, which are absent from the ACA
- Improving quality of care and outcomes by increasing access to care
- Reverse the trend toward for-profit, investor-owned healthcare plans
- Preserve physician's income potential, as judged by experience with the Canadian healthcare system

The authors devoted special attention to the cost of drugs and devices. They cited a study showing that pharmaceutical companies charge 50% more in the U.S. than in Europe for the same drugs. Much of the difference can be traced to large outlays for marketing and for a 20% profit margin, they said. By comparison, research and development (R&D) accounts for about 13% of drug costs.

The Department of Veterans Affairs gets a 40% discount on medication by buying in bulk. Medicare is legally forbidden to negotiate drug prices.

"Lower drug prices would not jeopardize drug innovation," Drasga and Einhorn stated. "Most true innovations in therapeutics (as opposed to me-too drugs that are slightly different versions of existing drugs) stem from publicly financed research."

The issue of drug pricing is especially relevant to oncology, they added, where the median cost of a new drug has risen to \$10,000 a month since 2010.

The authors called on ASCO to lead the way in advocating for a single-payer system, which would orient healthcare "toward care giving, not toward maximizing investors' profits."

ASCO has taken no position on a single-payer or other type of healthcare system, said ASCO chief executive officer Allen Lichter, MD.

"We have long advocated that every American deserves to have insurance coverage," Lichter told *MedPage Today*. "We have advocated that those patients who receive a new cancer diagnosis and don't have insurance should be placed into Medicare because facing a cancer diagnosis without insurance lowers your risk of survival, as Dr. Drasga and Dr. Einhorn pointed out in their paper."

## Payment Reform

Coinciding with the Drasga-Einhorn editorial, ASCO and the Community Oncology Alliance (COA) jointly issued principles for achieving payment reform in oncology.

The six principles focus on:

- Oncologists taking a leadership role in payment reform
- The inadequacy of current reimbursement models
- The need for new models for delivering oncology services to ensure high quality and value
- Retaining choices in payment models at the local level
- Improved measurement of quality
- The inadequacy and inequity of reimbursement for oncology drugs under Medicare Part B

The editorial provides "a good look at Nirvana," but most community-based oncologists would find it difficult to embrace, said Mark Thompson, MD, president of the COA, which represents

community oncology practices and centers.

"You can't dispute a lot of the facts that they lay out in the article," said Thompson, who practices at the Mark H. Zangmeister Center in Columbus, Ohio. "We do spend a huge amount of money in administering healthcare in the U.S.

"The difficulty that most of us who have spent any time in Washington -- and I've spent a lot of time there -- is the idea of making this public, which to me translates into government. I don't think we have a government or a Medicare program that can handle all of the wonderful suggestions that they talk about."

To the arguments against government-run programs, Drasga and Einhorn countered that "years of private-sector solutions have failed. There needs to be a major paradigm shift in our approach to funding healthcare in the U.S."

Strong opposition to a single-payer system is to be expected because a lot of money is at stake, Drasga told *MedPage Today*. Several academic oncologists turned down Drasga's offer of co-authorship before Einhorn accepted.

"I think they were afraid that it might hurt their relationship with pharma," he said. "A lot of research is funded by the pharmaceutical industry. There are a lot of powerful forces that do not want to see something like socialized insurance come along."

Nirvana or not, the single-payer approach is coming, Drasga continued. Vermont has set the process in motion by starting implementation of a state-run single-payer system. Total implementation is anticipated by 2017.

"Once one or two states get programs in place and see that they can save millions and millions of dollars, plus insure everybody, I think we could see a snowball effect," he said.

The Vermont program is envisioned as "kind of a Medicare for all, but at the state level," said Deb Richter, MD, a primary care physician from Montpelier who also is on the board of directors of Green Mountain Healthcare, the organization coordinating implementation of the state's single-payer plan.

Program leaders still have to jump through a lot of legislative and bureaucratic hoops (including waivers from the ACA and Medicare), but they remain optimistic the plan will be fully operational by 2017. The waivers could provide a portion of the funding for system, but the state still has to come up with extra revenue, currently estimated at \$1.6 to \$2 billion.

The Green Mountain board will submit revenue options to the state legislature in March.

When fully implemented, the plan will leave little business for private insurers, Richter said. The state plans to accept bids for administration of the system, but the market for private insurers will be limited to Vermonters who opt out of the state-run plan.

Whether support for a single-payer system catches fire remains to be seen, but reaction to the Drasga-Einhorn editorial has been limited thus far in the week-plus since the online article appeared, said journal editor John Cox, DO, of Texas Oncology in Dallas.

"The intention was to stir the pot the little, and I suspect we will because this is an issue that has a lot of strong feelings on both sides," Cox told *MedPage Today*.

*Charles Bankhead is a staff writer at MedPage Today.*

<http://www.medpagetoday.com/HematologyOncology/OtherCancers/44034>

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29 E Madison Suite 602, Chicago, IL 60602 ✉ [Find us on a map](#)  
Phone (312) 782-6006 | Fax: (312) 782-6007 | email: [info@pnhp.org](mailto:info@pnhp.org)  
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