Perspective

Why Oncologists Should Support Single-Payer National Health Insurance

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Oncologists face growing difficulties in caring for patients because of the rising cost of treatment coupled with the high prevalence of uninsurance and underinsurance. A diagnosis of cancer is often the single most catastrophic health care event in an individual's life. The stress of the situation increases exponentially when patients realize the burden of cost on themselves and their families.

Oncologists face the dilemma of advising a treatment schema that the patient can afford. Therapies may need to be compromised as a result of the patient's inability to pay. Patients often present with more advanced disease because they have never had cancer screenings because of a lack of insurance or concerns about cost. Meanwhile, the prices of cancer-related drugs are rising sharply, prompting some oncologists to sound the alarm.[1]

Different insurance plans have their own procedures for use review and benefit determinations, making it difficult for providers to interpret whether cancer treatment will be covered. The average patient finds it frustrating to navigate the bureaucracy with his or her life and financial security on the line. This article will outline the scope of these issues and offer an evidence-based case for single-payer national health insurance.

Situation Today

In 2011, US health spending was approximately $2.7 trillion and accounted for 17.9% of the gross domestic product.[2] Despite spending more, the United States ranks last of 16 developed countries in deaths that might have been prevented with timely and effective medical care.[3]

Cancer care accounts for at least 5% of total health care spending.[4] One survey showed one third of nonelderly insured patients with incomes of less than $75,000 did not have enough money to pay for medical care.[5] Another found that among uninsured patients with cancer, 27% said they went without care or delayed care for cancer.[6] A study of nonelderly patients with cancer found that 13.4% spent at least 20% of their income on health care costs compared with 4.4% of patients without cancer or chronic disease.[7]

According to the Census Bureau, 48.6 million people in the United States were uninsured in 2011—15.7% of the population.[8] Although the Patient Protection and Affordable Care Act (ACA) is expected to reduce this number in coming years, the Congressional Budget Office estimates that the law will nevertheless leave 31 million Americans uninsured in 2023.[9]

The problem of underinsurance, or insufficient coverage, is also expected to persist, if not worsen.[10] Insurance plans with limited networks of providers, along with high deductibles, copays, and out-of-pocket costs, are making underinsurance the new normal. The most affordable plans on the state health exchanges, the bronze and silver plans, leave 30% or 40% of health care costs, respectively, to be paid by policyholders.[11]

Single-Payer Insurance

Single-payer systems are systems in which a single public or quasipublic agency handles all health care financing. Delivery of care may remain in public or private hands, depending on the particular system.

The single-payer program we endorse is basically an improved Medicare for all. It would resemble the current arrangement in Canada in many ways. It would provide universal, comprehensive coverage with free choice of providers. All medical care would be covered, including provider visits, hospital care, prescription drugs, and rehabilitation. Copayments, deductibles, insurance premiums, and out-of-pocket expenses would be eliminated.

A single insurance plan for each region of the country would be administered by a public agency. This agency, which would be composed of elected or appointed laypersons and medical experts, would set health care policies and organize financing, decide benefits and establish the drug formulary, and have the power to negotiate prices for drugs and supplies and to negotiate fees with providers and hospitals. It would also be responsible for planning and new technology. Clinical decisions would be made by the physician and patient within that general framework. No longer would private insurance companies be in a position to decide, behind the scenes, what they will or will not cover.

The public agency would manage the plan and the health care budget in a transparent way. The allocation of available health resources (ie, rationing) would be guided by medical considerations, not on the basis of meeting corporate requirements for a return on investment or on the basis of a patient's ability to pay, the dominant forms of rationing in the United States today.

Financing the system could be accomplished by a mix of payroll and income taxes. Funds from Medicare and Medicaid would be retained. Several fiscal studies of single-payer national health insurance have shown that any increased tax burden on US households would be more than offset by the elimination of

insurance premiums and out-of-pocket costs for health care.[12,13] This would be a fair and sustainable solution.

Case for Single-Payer System

Administrative savings. Administrative overhead, including the enormous burden insurers impose on physicians and hospitals, consumes 31% of every health care dollar in the United States, double what Canada spends.[14] Although Canada has a single insurance plan in each province, in the United States, there are hundreds of insurance companies and thousands of different private plans. Every insurance company has departments for marketing, eligibility determination, claims processing, and use review, along with profits to fund. As a result, private insurance overhead averages 14% of premiums, compared with the traditional overhead of Medicare of just 1.4%.[15]

Overhead accounts for more than one quarter of all hospital spending in the United States because of the need to generate itemized per-patient bills for a plethora of plans and haggle over how much insurers will pay.[16] In contrast, Canadian hospitals are paid once a month and do not even have US-style billing departments.

Physician reimbursement is also much simpler under a single-payer system. In the United States, multispecialty group practices spend 13.9% of revenues for billing- and insurance-related overhead.[17] A recent study showed the United States spends 4× as much on billing and administration per physician as Canada does.[18]

Changing to a single-payer system like that in Canada would slash spending on insurance overhead as well as provider overhead, saving approximately $380 billion annually,[14,19] money that could be redirected to patient care. The savings would be enough to cover all of the uninsured and to eliminate copays and deductibles for everyone else.

Numerous state and national studies have shown that savings achieved from slashing bureaucracy with a single-payer system would be more than enough to provide comprehensive coverage for everyone with what we are currently spending on an inadequate system, including studies from the General Accountability Office, the Congressional Budget Office, and the Lewin Group, a consulting firm recently acquired by UnitedHealth Group.[20-22]

No other reform can slash overhead and generate this level of savings on administrative bloat. In contrast, in Massachusetts, the model for the ACA, the health exchange adds 4% to the cost of plans.[23]

Medical bankruptcies. A 2009 study found illness and medical bills were linked to 62.1% of the 1.4 million bankruptcies filed by families that year.[24] The uninsured were not the only patients affected. In fact, 78% of the individuals whose illness led to bankruptcy had health insurance at the onset of their illness, but it was inadequate or lost when the beneficiary could no longer work because of the illness.

Among bankrupted families, average out-of-pocket medical costs incurred since the onset of illness totaled $17,943; for patients with neurologic disorders, it rose to $34,167. In comparison, a 2008 study found that the median net household financial assets for insured families with incomes more than 300% of the poverty level was $5,700; the figure for uninsured households in the same income category was $100.[25] Another recent study showed that people with cancer diagnoses have a 2.65× higher rate of bankruptcy than people without such diagnoses.[26] The Massachusetts experience suggests that there will be no reduction in the rate of medical bankruptcy under the ACA.[27]

Being uninsured is bad for your health. Having no insurance is associated with a 1.40 hazard ratio for mortality compared with those with insurance.[28] The uninsured have a higher risk of death when compared with the privately insured, even after taking into account socioeconomic status, health behaviors, and baseline health. This translates into approximately 44,000 preventable deaths in the United States per year. Uninsured patients with cancer are 1.6× more likely to die within 5 years than their insured counterparts, according to a 2008 study by American Cancer Society researchers.[29]

Most health care in the United States is already taxpayer financed. The United States already has the highest taxpayer expenditure for health care in the world; however, it fails to deliver comprehensive care to everyone. Approximately 60% of US health care costs are publicly financed if taxpayer-paid premiums for private coverage for federal, state, and local government employees are included. In fact, US public spending on health care alone is more than what other developed countries spend from both public and private sources. In other words, we are already "paying for national health insurance and not getting it."[30pXXXX] Because they insure the healthiest segment of the population (age < 65 years, nondisabled, active workers), private businesses pay just 20% of the national health care tab.[31] AQ: C ★★

A single-payer system would also make financing health care more equitable. Currently, the poor and those with expensive illnesses like cancer pay a higher proportion of their incomes for health care than their wealthier counterparts.

Cost containment. For any reform to work, it needs to control the rising cost of health care, or any coverage expansions will be short lived. ACA does not include any cost-control measures proven to be effective. It launches an experiment in reviving the health maintenance organization (HMO) model of the 1990s—accountable care organizations (ACOs)—but there is no evidence that ACOs will be any more effective than HMOs were in containing costs.[32,33]

The most significant test of the ACO concept was the Medicare multiyear, 10-site physician group practice demonstration, which initially reported apparent savings of 1%, but on closer scrutiny, no actual savings were seen after taking into account diagnosis-coding differences.[34] Furthermore, the increase in consolidation among hospitals, physician groups, and other providers under the ACA is likely to increase costs.[35]

A recent study found that compared with the Canadian single-payer system, Medicare spending in the United States on the elderly has grown nearly 3× faster since 1980.[36] Although

traditional Medicare has a low administrative overhead, it is not a true single-payer system, because it coexists with many other private and public insurance plans. A hospital still has to do itemized, per-patient billing, and physicians still have to deal with onerous use review and different rules of multiple plans.[15]

Quality of care. Despite higher spending, the United States ranked sixth of seven countries in terms of quality in a 2010 cross-national study by the Commonwealth Fund, with only average performance on effectiveness and patient centeredness and low performance on safety and coordination.[37]

In terms of outcomes, the United States consistently ranks poorly in infant and maternal mortality, deaths resulting from asthma, and poor kidney and liver transplantation outcomes, but it does relatively well in some types of cancer care. A study of care in five countries (United States, United Kingdom, Canada, New Zealand, and Australia) in 21 areas found that the Untied States did well in breast cancer survival and had the highest screening rate for cervical cancer, but it ranked behind Australia and New Zealand in the treatment of non-Hodgkin lymphoma.[38]

Although superior survival rates in the United States for breast cancer and, in other studies, prostate cancer, may seem like a bright spot in our international performance, these may be artifacts of earlier diagnosis (lead-time bias) for these particular cancers or of excess diagnosis and treatment of cancer that would never have led to clinical disease.[39] On the other hand, uninsured patients with nearly every type of cancer present at later stages of diagnosis and have higher mortality rates.[40]

The biggest improvement the United States could make in improving the quality of care for cancer and other illnesses would be to assure universal access to treatment with no financial barriers to care.[41,42]

Investor ownership compromises care. During the past two decades, the US health care delivery system has undergone a transformation from its historic charitable roots to an investor-owned business. For-profit, investor-owned hospitals have higher spending on overhead than nonprofit hospitals, as well as higher costs.[14] Comprehensive literature reviews published in 2004 and 2002 found that for-profit hospitals cost 19% more and had 1% to 2% higher death rates than nonprofit institutions.[43,44] A more recent study of 3,229 hospitals found that the so-called best hospitals—those in the highest quartile of quality performance and lowest quartile of risk-adjusted costs—were more likely to have nonprofit status.[45]

For-profit nursing homes are higher priced and have lower quality of care.[46,47] For-profit hospices, which are soaring, are paid more per patient than nonprofit hospices because of an average longer length of stay, and they seem to seek out patients with diagnoses like dementia, for whom care is less costly to provide than patients with cancer.[48] They are less likely to provide palliative radiotherapy, a symptom reliever for patients with cancer.[49]

Physician incomes. On the basis of the Canadian experience, average physician incomes would remain approximately the same. Primary care physicians would likely make more, whereas specialist incomes may decline, narrowing the gap in incomes by specialty somewhat.[50] On the other hand, a single-payer system would reduce practice overhead and the time oncologists have to spend dealing with insurance and use review and allow more time for focusing on the delivery of high-quality clinical care to patients.

Drugs and Medical Devices

The cost of medications in the United States is higher than in any other developed country. The consulting firm McKinsey estimated that pharmaceutical prices in the United States are 50% higher than in Europe for the same medications, and 118% higher because of the more expensive US mix of drugs.[51]

Although drug companies claim their high US prices are needed to cover their research costs, they only spend 13% of their revenues on research and development compared with a much higher 31% on marketing and 20% on profit.[52] Lower drug prices would not jeopardize drug innovation. Most true innovations in therapeutics (as opposed to so-called me-too drugs that are slightly different versions of existing drugs) stem from publicly financed research.[53]

The Veterans Health Administration (VA) obtains a 40% discount on medications by negotiating prices with pharmaceutical firms and buying drugs in bulk. In contrast, Medicare is banned by law from negotiating prices with drug companies, and private Part D Medicare plans are far less effective than the VA at controlling drug costs.[54]

The cost of a new cancer drug has increased to a median price of $10,000 per month since 2010, and some drugs cost much more. Two drugs were priced at $35,000 per month.[55] Markups of drugs by hospitals and providers also can dramatically increase the prices of these drugs, particularly where insurance coverage is skimpy or absent.

Transition to Single-Payer Insurance

The transition to a single-payer system from our current financing arrangements will be challenging. It could be gradually implemented on a state-by-state basis, starting with one or two states, to lessen the administrative burdens.

At the same time, it is important to remember that Medicare was fully operational after only 1 year of its enactment, using paper records. Upgrading and expanding Medicare to cover everyone would be a fairly straightforward process, and legislation in Congress has been introduced outlining what such a plan could look like.[56]

Patients would register only one time and be covered by national health insurance for life. Investor-owned hospitals and clinics could be purchased by the public plan and be converted to nonprofits. People working in the private insurance industry would be entitled to retraining and placement. Many could work in new jobs in the single-payer system. Retraining and placement would only cost a fraction of the administrative savings from the transition to a single-payer system.

Congress will need to adopt such a law. The political obstacles, particularly opposition from lobbyists and other actors

representing the interests of the private health insurance industry, the multinational drug companies, investor-owned hospitals, and other large, for-profit providers in the US system, will undoubtedly be formidable. However, the widely recognized economic unsustainability of our present arrangements, combined with an appreciation of the proven ability of broad-based social movements in the United States to change existing power relationships (eg, women's suffrage and civil rights movements), suggests such a shift is achievable. In this connection, it is worth noting that surveys of the public and of physicians in the past two decades have shown that an improved Medicare for all approach enjoys solid majority support.[57,58]

The US path to a single-payer system will no doubt be unique. Canada started with only one province in 1946, and others followed later. The National Health Service in the United Kingdom was created in the wake of World War II and the attendant economic hardship. Taiwan swiftly converted to a single-payer system in 1995 without major difficulties.

Discussion

Cancer leaves a patient in his or her most vulnerable state not only physically but financially. Oncologists are in a unique position to champion the cause of improving access to care for patients with cancer and easing the financial burden they and their families face.

With ACA now the law of the land, and its retention of the private insurance industry at the center of the health system, the trend toward high-deductible health plans, underinsurance, and cost shifting to patients will almost certainly worsen.[59] Years of private-sector solutions have failed. There needs to be a major paradigm shift in our approach to funding health care in the United States.

How can we ethically and with dignity provide equal access to all patients with cancer while still controlling cost? Instead of an expensive, exclusionary, for-profit, market-based system that siphons off nearly one third of every health care dollar to bureaucracy in the quest for profit, we need a streamlined, efficient, nonprofit system based on human needs to provide high-quality care to every person: single-payer national health insurance.

In conclusion, because ACA will fail to remedy the problems of the uninsured, the underinsured, rising costs, and growing corporate control over caregiving, we cannot in good conscience stand by and remain silent. Life is short, especially for some patients with cancer; they need help now. We call on the American Society of Clinical Oncology (ASCO) to advocate for a single-payer national health insurance program. Our medical system must be oriented toward caregiving, not toward maximizing investors' profits.

Is this concept too idealistic to become a political reality? We think not. Because a single-payer system is a sensible and realistic solution, we believe its achievement is possible with sufficient understanding among the public and their elected representatives.

All of our patients deserve dignity. It is our moral and ethical obligation as physicians to advocate for universal access to health care. Oncologists, working in conjunction with ASCO, are well positioned to educate legislators about single-payer national health insurance. The time to start is now.

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References

1. Cavallo J: Oncologists speak out against the high cost of cancer drugs. http://ascopost.com/issues/august-15,-2013/oncologists-speak-out-against-the-high-cost-of-cancer-drugs.aspx

2. Hartman M, Martin AB, Benson J, et al: National health spending In 2011: Overall growth remains low, but some payers and services show signs of acceleration. Health Aff (Millwood) 32:87-99, 2013

3. Nolte E, McKee M: Variations in amenable mortality: Trends in 16 high-income nations. Health Policy 103:47-52, 2011

4. Agency for Healthcare Research and Quality: Chart 4: The five most costly conditions as a percentage of total health expenditures—United States, 2002. http://www.ahrq.gov/research/findings/factsheets/costs/expriach/expriach4.html

5. USA Today, Kaiser Family Foundation, Harvard School of Public Health: Health care costs survey. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7371.pdf

6. USA Today, Kaiser Family Foundation, Harvard School of Public Health: National survey of households affected by cancer. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7591.pdf

7. Bernard DS, Farr SL, Fang Z: National estimates of out-of-pocket health care expenditure burdens among nonelderly adults with cancer: 2001 to 2008. J Clin Oncol 29:2821-2826, 2011

8. DeNavas-Walt C, Proctor BD, Smith JC: Income, poverty, and health insurance coverage in the United States: 2011. http://www.census.gov/prod/2012pubs/p60-243.pdf AQ: G

9. Congressional Budget Office: Table 1: CBO's May 2013 estimate of the effects of the Affordable Care Act on health insurance coverage. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf

10. Woolhandler S, Himmelstein DU: Life or debt: Underinsurance in America. J Gen Intern Med 28:1122-1124, 2013

11. Kaiser Family Foundation: Focus on Health Reform: What the actuarial values in the Affordable Care Act mean. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf

12. Rasell E: An equitable way to pay for universal coverage. Int J Health Serv 29:179-188, 1999

13. Friedman G: Funding HR 676: The expanded and improved Medicare for All Act: How we can afford a national single-payer health plan. http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf

14. Woolhandler S, Campbell T, Himmelstein DU: Costs of health care administration in the United States and Canada. N Engl J Med 349:768-775, 2003

15. Sullivan K: How to think clearly about Medicare administrative costs: Data sources and measurement. J Health Polit Policy Law 38:479-504, 2013

16. Woolhandler S, Himmelstein DU: Costs of care and administration at for-profit and other hospitals in the United States. N Engl J Med 336:769-774, 1997

17. Kahn JG, Kronick R, Kreger M, et al: The cost of health insurance administration in California: Estimates for insurers, physicians, and hospitals. Health Aff (Millwood) 24:1629-1639, 2005

18. Morra D, Nicholson S, Levinson W, et al: US physician practices versus Canadians: Spending nearly four times as much money interacting with payers. Health Aff (Millwood) 30:1443-1450, 2011

19. Woolhandler S: Cutting health costs by reducing the bureaucracy. New York Times, November 20, 2011:A28

20. US General Accounting Office: Canadian health insurance: Lessons for the United States. http://archive.gao.gov/d20t9/144039.pdf

21. Congressional Budget Office: Universal health insurance coverage using Medicare's payment rates. http://www.cbo.gov/ftpdocs/76xx/doc7652/91-CBO-039.pdf

22. Sheils JF, Haught RA: The Health Care for All Californians Act: Cost and economic impacts analysis. http://www.lewin.com/publications/Publication/161

23. Ways to reduce the cost of health insurance for employers, employees and their families. Hearing before the Subcommittee on Health, Employment, Labor and Pensions of the Committee on Education and Labor, 111th Cong, 1st Sess, April 23, 2009

24. Himmelstein DU, Thorne D, Warren E, et al: Medical bankruptcy in the United States, 2007: Results of a national study. Am J Med 122:741-746, 2009

25. Jacobs PD, Claxton G: Comparing the assets of uninsured households to cost sharing under high-deductible health plans. Health Aff (Millwood) 27:w214-w221, 2008

26. Ramsey S, Blough D, Kirchhoff, et al: Washington state cancer patients found to be at greater risk for bankruptcy than people without a cancer diagnosis. Health Aff (Millwood) 32:1143-1152, 2013

27. Himmelstein DU, Thorne D, Woolhandler S: Medical bankruptcy in Massachusetts: Has health reform made a difference? Am J Med 124:224-228, 2011

28. Wilper AP, Woolhandler S, Lasser KE, et al: Health insurance and mortality in US adults. Am J Public Health 99:2289-2295, 2009

29. Ward E, Halpern M, Schrag N, et al: Association of insurance with cancer care utilization and outcomes. CA Cancer J Clin 58:9-31, 2008

30. Woolhandler S, Himmelstein DU: Paying for national health insurance: And not getting it. Health Aff (Millwood) 21:88-98, 2002

31. Carrasquillo O, Himmelstein DU, Woolhandler S, et al: A reappraisal of private employers' role in providing health insurance. N Engl J Med 340:109-114, 1999

32. Marmor T, Oberlander J: From HMOs to ACOs: The quest for the holy grail in U.S. health policy. J Gen Intern Med 27:1215-1218, 2012

33. Berenson RA: Shared savings program for accountable care organizations: A bridge to nowhere? Am J Manag Care 16:721-726, 2010

34. Iglehart JK: Assessing an ACO prototype: Medicare's physician group practice demonstration. N Engl J Med 364:198-200, 2011

35. Creswell J, Abelson R: New laws and rising costs create a surge of supersizing hospitals. New York Times, August 12, 2013:B1

36. Himmelstein DU, Woolhandler S: Cost control in a parallel universe: Medicare spending in the United States and Canada. Arch Intern Med 172:1764-1766, 2012

37. Davis K, Schoen C, Stremikis K: Mirror, mirror on the wall: How the performance of the US health care system compares internationally, 2010 update. http://www.commonwealthfund.org/Publications/Fund-Reports/2010/Jun/Mirror-Mirror-Update.aspx?page=all

38. Hussey PS, Anderson GF, Osborn R, et al: How does the quality of care compare in five countries? Health Aff (Millwood) 23:89-99, 2004

39. Welch HG, Schwartz LM, Woloshin S: Are increasing 5-year survival rates evidence of success against cancer? JAMA 283:2975-2978, 2000

40. Halpern MT, Ward EM, Pavluck AL, et al: Association of insurance status and ethnicity with cancer stage at diagnosis for 12 cancer sites: A retrospective analysis. Lancet Oncol 9:222-231, 2008

41. Schiff GD, Bindman AB, Brennan TA: A better-quality alternative: Single-payer national health system reform—Physicians for a national health program quality of care working group. JAMA 272:803-8, 1994

42. Woolhandler S, Himmelstein DU, Angell M: Proposal of the Physicians' Working Group for Single-Payer National Health Insurance. JAMA 290:798-805, 2003

43. Devereaux PJ, Heels-Ansdell D, Lacchetti C, et al: Payments for care at private for-profit and private not-for-profit hospitals: A systematic review and meta-analysis. CMAJ 170:1817-1824, 2004

44. Devereaux PJ, Choi PT, Lacchetti C, et al: A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. CMAJ 166:1399-1406, 2002

45. Jha AK, Orav EJ, Epstein AM: Low-quality, high-cost hospitals, mainly in South, care for sharply higher shares of elderly black, Hispanic, and Medicaid patients Health Aff (Millwood) 30:1904-1911, 2011

46. Harrington C, Woolhandler S, Mullan J, et al: Does investor ownership of nursing homes compromise the quality of care? Am J Public Health 91:1452-1455, 2001

47. Comondore VR, Devereaux PJ, Zhou Q, et al: Quality of care in for-profit and not-for-profit nursing homes: Systematic review and meta-analysis. BMJ 339: b2732, 2009

48. Wachterman MW, Marcantonio ER, Davis RB, et al: Association of hospice agency profit status with patient diagnosis, location of care, and length of stay. JAMA 305:472-479, 2011

49. McCue MJ, Thompson JM: Operational and financial performance of newly established hospices. J Hosp Palliat Care 23:259-266, 2006

50. Duffin J: The impact of single-payer health care on physician income in Canada, 1850-2005. Am J Public Health 101:1198-1208, 2011

51. Farrell D, Jensen E, Kocher B, et al: Accounting for the cost of US health care: A new look at why Americans spend more. http://www.mckinsey.com/insights/health_systems_and_services/accounting_for_the_cost_of_us_health_care

52. Light DW, Warburton RN: Extraordinary claims require extraordinary evidence. J Health Econ 24:1030-1033, 2005

53. Light DW, Lexchin J: Foreign free riders and the high price of US medicines. BMJ 331:958-960, 2005

54. Frakt AB, Pizer SD, Feldman R: Should Medicare adopt the Veterans Health Administration formulary? Health Econ 21:485-495, 2012

55. Bach PB, Saltz LB, Wittes RE: In cancer care, cost matters. New York Times, October 15, 2012:A25

56. Expanded and Improved Medicare for All Act, HR 676, 113th Congress, 1st Sess, 2013. http://beta.congress.gov/bill/113th-congress/house-bill/676?q=hr+676

57. Sullivan K: Two-thirds of Americans support Medicare for all. http://www.pnhp.org/sites/default/files/docs/2011/Kip-Sullivan-Two-thirds-support-medicare-for-all.pdf

58. Carroll AE, Ackerman RT: Support for national health insurance among U.S. physicians: 5 years later. Ann Intern Med 148:566-756, 2008

59. Himmelstein DU, Woolhandler S: Obama's reform: No cure for what ails us. BMJ 340:c1778, 2010

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