How Big Pharma makes a killing on patients' suffering

Dispatcher: 911, what's your emergency?

Caller: America's healthcare system is broken and people are dying! (ambulance siren)

Welcome to **Code WACK!**, where we shine a light on America's callous healthcare system, how it hurts us and what we can do about it. I'm your host, **Brenda Gazzar**.

This time on Code WACK! Why are some cancer drugs so incredibly expensive? How do some drug companies and health insurance companies choose profit over patients? To find out, we spoke to **Dr. David Leibowitz,** who conducted lab research for about 20 years before spending another 20 as a hematologist oncologist helping cancer patients. (Hematology is the study of blood.)

Now retired, Leibowitz fights for improved Medicare for All and is the incoming chairman of Physicians for a National Health Program-California, a non-partisan voluntary organization that supports equitable access to high quality health care as a right to all people.

Welcome to Code WACK!, Dr. Leibowtiz.

(01:04):

Leibowitz: Thank you. It's a pleasure to be here.

(01:06):

Q: It's a pleasure to have you. So tell us a bit about yourself. Why did you decide to go into medicine and why oncology specifically?

(01:14):

Leibowitz: So I decided to go into medicine because it was a way to do science that I enjoyed, and it was also something that I thought would help mankind, help make the world a little better place. So I came to hematology or oncology and the way that happened, it was through the lab because when I was in medical school, I started working in a lab that was doing hematology related research, and I enjoyed that so I just kept doing it and so when it came time to do a fellowship, I did it in hematology oncology again, cuz I could continue that kind of lab work and I did lab work for kind of the first half of my career and then I decided I was tired of supervising a lab and I wanted to work more with people so I went into practice and my practice was mainly hematology, benign and malignant, but also some kind of more straightforward oncology.

(02:15):

Q: So after 20 years in research, you began seeing patients? That must have been quite a change.

(02:21):

Leibowitz: So I was seeing patients all the time that I was in the lab also, but not as often, but I had clinics during that time.

(02:29):

Q: Got it. So did seeing patients more often affect your understanding of the challenges they face as they cope with cancer?

(02:36):

Leibowitz: Absolutely. Because even having a clinic, you don't quite get the exposure to the problems people have paying for things and that's a big problem for a lot of people.

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Q: Yeah. Can you tell us more about that? Do you have any stories of patients, for example, that you can share?

(02:56):

Leibowitz: One was a man who was actually a retired doctor and he had an illness called multiple myeloma. This was like about 15 years ago and there was a new medicine that was available, an oral pill, but it was very expensive. And in spite of the fact that he was a retired physician – so you might think that he should have been able to afford it – he could not afford it. It angered me because it turns out that that medicine makes people live long and relieves a lot of symptoms, so that bothered me.

(03:29):

Q: So what happened to this gentleman?

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Leibowitz: Well, eventually he passed away from his illness. There was no way at the time that I could get the medication for him. It was just starting to be used for myeloma at the time and so it was very, very expensive.

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Q: Wow. Do you remember how expensive it was?

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Leibowitz: Oh, it was one to $2,000 a month. Yes. a lot of the medicines when they're new are very expensive and for quite a long time, Medicare would not pay for oral medications. That's changed to some extent, but for many years they wouldn't pay for oral medications and so people were really stuck.

Wow.

Leibowitz: Cause on the one hand, we're delighted to have an oral medicine because it means people don't have to travel to an infusion center and they don't have to sit for hours and get IV medications but at least at that time it also meant they had to pay for it themselves.

(04:28):

Q: So this patient, did he just go without medicine?

(04:31):

Leibowitz: He went without that particular medicine, there were other medicines we could treat him with that we did treat him with, but he probably would've lived longer and more comfortably if we could've used the expensive medicine.

(04:44):

Q: How did that make you feel?

(04:46):

Leibowitz: Well, it made me angry and sad – both of those things.

(04:51):

Q: Thank you for sharing that. And you mentioned another case?

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Leibowitz: It's frighteningly similar. This was a man who had prostate cancer and we've been very lucky in that prostate cancer in the last 10 years or so has had a bunch of new medicines come on the market, which make quite a bit of difference for patients....Chemotherapy for prostate cancer is still not terribly effective by itself, but these new medicines again were not chemotherapy. They were a brand new way of affecting the hormonal control of the cancer and they were really great, but in the same way that happened with the first person, it was an oral medicine and it was enormously expensive. It was also over a thousand dollars a month and I actually had a number of patients who could not afford it when it first came out. Again, that really is infuriating cuz I mean we are a very rich country and there are a lot of very successful companies in the world of health care and you would think that we should be able to take care of people.

(06:08):

Q: It's so true. So the second patient who couldn't afford the medicine for prostate cancer, what happened to him?

(06:16):

Leibowitz: You know, so we would treat him with all the other options and there are other options. They cause more side effects than the new group of medicines does and today we know also about combinations of medicines that work more effectively. But the problem is that, you know, when a medicine is new, there's no

generic equivalent and basically it's whatever the market will bear in terms of the price that's set.

(06:46):

Q: Got it. I can imagine that drug companies just wouldn't want there to be a generic version because once there is, they'll miss out on a great deal of money, right?

(06:55):

Leibowitz: Well, yeah, there are a number of great stories about how the pharmaceutical companies handle that. It's not that uncommon that they buy the company that is making the generic and then one of two things can happen. They may continue making the generic with the company they bought or in some cases they shut down the company and so there is no generic available.

(07:18):

Q: And that's legal in America?

(07:20):

Leibowitz: It is legal.

(07:21):

Whoa, that's insane.

(07:24):

Leibowitz: Yes. that's a good word for it. <Laugh> And unfortunately, you know, insulin is a great example, I mean that's not a new medicine. That's been around for a very long time, but suddenly the price has gone up so much that a lot of diabetics are having problems affording it so it's not just the new medicines. And I guess the other catch is that when a medication is starting to approach the time that it would come off patent, it's not uncommon that a company will try to make some little chemical change in the medication so that they can patent it again. There are a lot of clever ways to kind of cheat in the system.

(08:07):

Q: So interesting. What about your patient struggles with health insurance? Do you have any stories you can share about that?

(08:14):

Leibowitz: The prostate cancer story is really about that because a lot of times the insurance could cover the medication if it chose to and that gets into the whole story about authorization and preauthorization and the ways in which health insurance companies control what doctors are allowed to do in their practice, and that actually is becoming a major issue because today 60% to 70% of physicians are employed. They no longer have their own little independent practice.

They're now employed by hospitals or healthcare corporations and the really sad part is that many of those healthcare companies are being purchased by private equity firms. So before they were purchased, they were for-profit companies. After they're purchased by private equity, there's really no kind of pretense that they have a benevolent motivation cuz private equity is strictly dedicated to taking as much money out of a company as possible.

(09:29):

But even without considering private equity, if the company is for profit, the way you make a profit in insurance is by not paying anything out and in medical insurance, that means you don't pay for medical care. So companies try to avoid paying for expensive medications. They try to avoid paying for expensive treatments. One of the newest types of treatments for a few different kinds of cancer is a kind of specialized kind of bone marrow transplant – stem cell transplant. And you know, of course that's just starting up and is very expensive because it requires hospitalization, which is enormously expensive in the United States and insurance companies have been doing their best to avoid letting patients have that treatment. Luckily to some extent they get forced into it if it's very clear that that's the best treatment for the patient.

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Q: So it sounds like in some cases they don't get forced into it?

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Leibowitz: Exactly.

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Q: So what happens then?

(10:41):

Leibowitz: The patient doesn't get that particular treatment. They'll get some other treatment. It may not be as good. That's the problem with the way our healthcare system has developed. It wasn't always quite this dramatic, but over the last 20 to 30 years, the motivation to pull money out of the system as profit has gone up dramatically. If you look at graphs, comparing a variety of different things, comparing the United States to similarly developed countries until 20 or 30 years ago, there wasn't that much difference between the United States and all those other countries. But since then there has developed a dramatic difference in how much we spend on health care, on how long we live and how many mothers and babies die. And it's not going in the right direction.

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That's so sad and scary to think about.

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Leibowitz: Absolutely.

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Q: So how would single payer Medicare for All help remedy these challenges?

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Leibowitz: Well, that's a great question. One immediate thing is that you'd eliminate the for-profit dollars and that would probably amount to about one third of what we are now paying and that money would almost pay for the single-payer system, not completely, but it's clear that single payer would save quite a lot of money, the total expenditure and you know, it varies from one estimate to another. Some estimates say that the savings would start in the first three years. Some estimates say, you'd have to be at 10 years before you start seeing the dramatic savings, but it would absolutely stop the incredible rise in costs in our system because you get rid of profit and you also eliminate administrative waste because the administrative costs in the U.S. system, since you have a whole variety of different insurers, each of which has their own set of criteria for what they'll pay for and how they want the claim submitted, doctors have to pay for a team of people, billing and talking to the insurance companies. Care gets delayed, sometimes with terrible consequences and that takes up about 20% of our healthcare dollars. And in most of the other comparable countries, that figure is 9% to 10%. The Medicare system in the United States, the administrative costs are only two to 3%. The estimates are that if you had a single-payer system, it would probably be around 5%. So it would not be quite as low as Medicare right now, but it would be

dramatically lower than what we're spending and it would probably be lower than most of the other advanced countries.

(13:43):

Q: So how would saving money and getting rid of the administrative and cost burden help patients?

(13:50):

Leibowitz: Ah, yes, that's the most important part of it. So it would mean that lots more things would be covered by insurance — vision care, hearing, dental care, long term care, which is an enormous item, particularly in the United States.

(14:11):

Q: Like nursing home care?

(14:12):

Leibowitz*:* Exactly and also there wouldn't be any insurance premiums. There wouldn't be any deductibles. There wouldn't be any copays and there wouldn't be any costs for medication. So it would be a whole new ballgame and one of the things that this is one thing that irritates me in terms of the debate about this. Sometimes you'll hear people say that putting together Medicare for All or a single-payer system would increase everyone's taxes and that's very deceptive because taxes might go up, but the actual costs for families would go way down.

(14:52):

Q: For health care?

(14:54):

Leibowitz: Exactly, exactly. Well, yes. Right. Most families would end up saving money.

(15:00):

Q: Good to know you were recently named chairman of Physicians for a National Health Program - California, which advocates for Medicare for All. Congratulations. What's your vision for the chapter and what are your goals?

(15:13):

Leibowitz: Well, the goals of course, would be to have a single-payer national healthcare system. There is debate within the group about, you know, how happy would we be if we had a single-payer system in one state. Some people feel like we ought to just focus on a national system. I think everybody would agree that a national system is the goal, but other people would argue that that is the goal, but maybe we need to start in one state or a group of single states at a time because Canada actually started in a single province and then the system got generalized. So my goal would be that PNHP has a large enough group of doctors who feel strongly and are committed to advocating for a single-payer system. The sense is that even though doctors are not by number an enormous voting block, people do still feel that doctors know something about how health care should be delivered and so we'd like to have a large enough group of doctors advocating for single payer so that the general public believed them and came to support single payer.

(16:31):

Thank you, Dr. David Leibowitz. Do you have a personal story you'd like to share about our 'wack' healthcare system? Contact us through our website at heal-ca.org.

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