



Why the Same Drug Costs 3x More (And Who Decides)

Host:

Imagine two patients. Same diagnosis. Same medication. Same country, but one gets their care through the VA, the Department of Veterans Affairs. The other goes through Medicare.

The price of the exact same drug? For one patient, it could be half as much. For the other, it can be sometimes two or even three times higher, not because the drug is different, but because one system negotiates prices and the other mostly doesn't.

That's not a glitch. It's how the system is designed — and once you see that, a bigger question emerges. If the system works this way, why haven't we changed it?

Welcome to **Code WACK!** where we break down how our healthcare system really works, what it means for you and how we can make it better for everyone. I'm your host, **Brenda Gazzar.**

This is part two of our conversation based on **Bob Coleman's** new ebook, **Hostile Takeover.** Bob's a retired healthcare professional who spent more than 40 years

serving veterans through the US Department of Veterans Affairs as a clinical pharmacist, medical informaticist, and researcher.

Welcome back to Code WACK Bob!

So if the core problem is how the system is structured, what keeps that structure in place?

In the ebook, Hostile Takeover: How Wall Street and Congress Hijacked American Healthcare and How We Can Take It Back, you refer to a political protection racket. What do you mean by that? And how does it help sustain a system that many argue is both costly and harmful?

Coleman: I wanna be very clear, I'm not suggesting anything illegal, but perhaps conspiratorial. I'm describing a structural pattern of incentives and influence that exist in large systems and particularly in our healthcare system. And the US healthcare system is really large. The GDP of the United States is around \$5 trillion, and the healthcare system is around 20% of that at that scale, and that much money and that higher percentage of our economy that's naturally deeply connected to politics and policy. There is substantial lobbying by healthcare sectors. There's campaign contributions and ongoing engagement with policy makers. Over time, these forces create alignment between economic interests and political decision making.

Host: Got it. So this isn't some abstract theory. This pattern shapes what you pay for insurance, how much your prescription costs and what care you can actually get.

Coleman: The result is not a single decision or actor. It's a system that tends to stabilize itself and resist major structural change, even when the system has high cost, administrative complexity, and barriers to care. So when I use the phrase

protection racket, I'm describing a system where the economic and political incentives align to protect the status quo.

Host: In other words, we're feeding the beast. The system continues, not because it works well, but because it's catering to the corporate incentives inside of it.

So if the problem is the structure, what would a different system look like?

You make the case for single payer healthcare. Why do you believe this approach addresses the core problems you've outlined?

Coleman: Single payer is the most efficient, equitable, and logical system. It's practiced by every G-7 country in every industrialized nation except the United States. If the problem is misaligned incentives, then the solution has to be realign the incentives. A single-payer model provides that opportunity. For example, universal eligibility for all, truly comprehensive benefits that include hospital, outpatient, prescription, dental, vision, mental, and some of the proposals even have long-term care.

So instead of multiple insurance plans, different rules and unpredictable costs, this would mean one system designed to cover everyone.

Coleman: We could start doing drug price negotiation. So the VA system negotiates drug prices and the cost of drugs within the VA is [about] one half what it is to regular public under part D of Medicare. And if you could pair that to the United Kingdom, which strongly negotiates drug prices, the US costs are three times the costs that are in the UK.

Most importantly, it shifts the focus toward prevention, early care and population health.

Host: So that difference we heard at the beginning, the same drug, different price, comes down to how the system is set up.

Great. I wanna step back for a second, because this wasn't always your position. At one point you were considering a completely different approach. So what changed?

Coleman: When I first wrote Hostile Takeover, my plan to take it back was a federal plan, an extension of the VA nationwide, which is very much like the system in the UK. The UK system is very efficient. It saves a lot of money, provides good universal care, and in that system, the government owns all the hospitals and the government pays the provider. This is not necessarily a system that's gonna play [out] in the United States.

And that's where I became involved with the Washington Trust, that was like being taken to water because the Washington Trust has an entire plan, and that plan has been a compilation of what's gone on in [single payer] healthcare at the state level for years. So there's a little bit of Vermont's plan, there's a little bit of the California plan, there's a little bit of the Oregon plan. As I've started taking that apart, it became very clear to me this is probably the most viable initial path.

Host: So for our listeners, this isn't just theory. These are real single payer proposals being developed and tested at the state level. So how does single payer support prevention?

Coleman: Under the current system, healthcare companies get a percent of the premium. Their premiums are their source of funds, and they get 80% of it is about what they get. And that's locked in by law. So if you're dealing with high cost patients, the premiums go up, they're getting a fixed percentage. So as the cost of the system goes up, the insurance companies get more money. And so there's incentive to have the system be high cost. There's incentive to have the drugs be high cost, and there's no incentive in that system for prevention. If you prevent disease, you lower your profit.

Host: So the system makes more money when people are sicker.

Coleman: Single payer changes the rules of the game. In a single payer system, the money is paid into the system, and any money you save by prevention is saved by the system. It aligns the system around health, instead of around billing,

Host: That could mean earlier care, fewer delays and potentially fewer serious illnesses.

Coleman: All that's needed is the political will to do it and let it be proved somewhere. And I think that's really important. What Washington is doing and what other states are doing is trying to get single payer in at the state level. That can be sort of a launching pad for extending single payer across the country.

Host: There are state and national single-payer efforts. Do you think there are pros and cons of each path?

Coleman: I do. If you look at the federal level. The first part of it is that healthcare operates on a national scale. So a federal approach provides consistency across states, administrative efficiency, full risk pooling across the entire population, maximum negotiating power for drugs and services. But better reform is politically very difficult. It requires a broad national consensus, faces incredible resistance for multiple stakeholders and involves a large-scale system transition. State level reform is, I think, more feasible, smaller political environments.

There's more flexibility. States can serve as laboratories for innovation, test new payment models, it can experiment with coverage systems and demonstrate what works in practice.

But state approaches have real limitations. Smaller risk pools, more financial volatility, limited negotiating power and challenges when people move between states. I think the most realistic path is a state level innovation and proof of concept leading to federal alignment and scaling. Because ultimately health care is [indecipherable] states can lead the way, but the system ultimately needs national alignment.

Host: So this is why you're hearing about reform at the state level. It's a way to prove what works before scaling nationally.

Coleman: I think there's gonna need to be a couple of states that do it and prove it before there's enough political buy-in for Washington to get on board.

Host: Got it. What practical steps can individuals take?

Coleman: I think with the healthcare system, and it is, it's overwhelming. Change in large systems does not happen at once. And so in my mind, put together this little loop of what I think needs to happen for reform. The first part of that loop is understanding and awareness. Once the public gets educated, the next step is civic and political engagement. Contact representatives of town halls, ask healthcare specific questions, support candidates focused on reform. Until there's the political will to do it, it's not really gonna happen. And as we create awareness, it becomes influence. As the public awareness grows, priorities shift, elected officials respond, policy discussions change.

Host: So even understanding how the system works is part of how change begins. Is there anything else you'd like our audience to understand, Bob?

Coleman: Healthcare systems produce the outcomes their incentives reward. The issue is not the quality of medicine, it's the structure and incentives surrounding care. And once people begin to see that clearly, the conversation changes and so does the possibility of reform. In summary, the problem in American healthcare isn't medicine. It's the incentives shaping the system. And to change that system, we need a single payer healthcare system.

Host: That's the key idea. The system isn't just broken, it's producing exactly what it was designed to produce. And if we want different outcomes, we have to change the incentives behind it.

You can order Bob Coleman's new ebook, "Hostile Takeover, How Wall Street and Congress Hijacked American Healthcare and How We Can Take it Back" on Amazon. If this episode helped you understand our healthcare system, share it with someone else.

Fed up with our wack healthcare system, call the US Capitol Switchboard and ask to be connected to your representatives using your zip code. Tell them you're ready for single-payer Medicare for All. It takes just a few minutes, and believe me, your voice does count.

You can reach them at 202-224-3121. That's 202-224-3121.

Thanks for listening to Code WACK!

Stay informed, stay engaged, and most of all, stay healthy.