The Dangers of Single-payer Systems for Cancer Patients

Executive Summary

- Single-payer systems often face shortages of the health care providers required for timely and accurate diagnosis of cancer; as demand for anti-cancer therapy increases, those shortages will become more pronounced.
- Even if there are enough doctors to provide care in any single-payer system, restrictions on access to innovative therapies – which are often costly – are a fundamental way in which single-payer systems manage costs.
- The United States' mix of public and private payers promote speedier diagnosis and treatment of diseases such as cancer; maintaining this access for patients should be a priority for policymakers and the health care industry, alike.

Introduction

Cancer is one of the most ubiquitous health challenges facing people around the world. Cancer incidence rates are rising, with a projected 35.3 million cancer cases worldwide by 2050. The United States' mix of public and private payers has typically ensured that Americans have much speedier access to innovative and specialized cancer treatment than those living under single-payer systems. The reason is simple: Single-payer systems often can't accommodate population needs or simply refuse to pay for necessary services or treatments – regardless of the potential patient benefit – to maintain a budget.

In single-payer systems, it is typically the central government or a deputized agency, such as the National Health Service (NHS) in the United Kingdom (UK) or Health Canada in Canada, that makes determinations about appropriate coverage and where to spend resources. Every year, the government in a single-payer system must set its spending level on health care, essentially determining the amount of care that can be given over the course of the budgeted timeframe. As previously discussed in the Reality Check-Up, wait times are a feature and not a bug of single-payer systems because they are used as budgeting tools.

Timely Access to Doctors in the UK Single-payer System Is Not Guaranteed

In December of 2023, nearly one in five patients – or about 90,000 people – in the NHS were waiting longer than six weeks to receive their imaging (CT or MRI) test. In 2023, more than 745,000 patients waited longer than four weeks for their imaging test. These delays in care pose significant challenges for determining any diagnosis and, if warranted, the necessary treatment pathway.

Why did these delays occur? It's because the NHS has a shortage of practitioners to perform diagnostics and treat patients after getting results. The Royal College of Radiologists (RCR), the leading professional society representing the UK's radiologists and oncologists, reported a 30-percent shortage of clinical radiologists in 2023. By 2028, this number is expected to rise to 40 percent, representing a shortage of more than 3,500 radiologists.

In its 2023 Clinical Radiology Workforce Census Report, RCR warned: "Delays in treatment have become routine, with 91 percent of clinical directors stating that workforce shortages were impacting patient safety." To improve the situation, RCR recommended: "The NHS should not only maintain but expand the number of specialty training posts for clinical radiology to keep up with rising demand."

In theory, growing the workforce to alleviate these shortages could be solved with greater funding to train future doctors. Structurally, however, such an undertaking would be monumentally difficult. The NHS puts the burden of 50 percent of this funding on local trusts. Local trusts are an organizational body within the NHS that provides care to certain communities in a particular geographic location. They are semi-autonomous, meaning that while they are part of the NHS family, they independently manage their own funds relating to health care services designation and decision making. Mounting financial pressures due to backlogs, inflation, and other external costs have made it so that securing this 50 percent of local trust funding is nearly impossible for many radiology departments.

These workforce issues have real effects on patient care in several ways. In 2023, RCR reported that demand for systemic anti-cancer therapy, such as chemotherapy, grew by 6 to 8 percent, while the consultant workforce (which itself is used in part to make up the shortfall) expanded at half that rate. Cancer Research UK, a national charity that funds cancer treatment research, recently reported that in 2024 both the NHS' standards for 62-day referral to treatment (RTT) and 31-day decision to treat (DTT) were missed. The RTT, which measures whether a person that received a cancer diagnosis starts their first treatment within two months of referral, was only measured at 71 percent completion. Moreover, the 62-day RTT standard has not been met since December 2015. For every four-week delay in care, the risk of death from cancer rises by around 10 percent.

Single-payer Systems Put the Most Innovative Treatments Out of Reach

Even if there are enough doctors to provide care in any single-payer system, restrictions on access to innovative therapies are a fundamental way in which single-payer systems manage costs.

Take the case of Kadcyla, a therapy used to treat breast cancer. Clinical trials showed that Kadcyla extended patient survival by an average of six months in comparison to existing treatments. In 2013, the U.S. Food and Drug Administration (FDA) approved Kadcyla for breast cancer patients; insurers quickly began covering the drug and allowing patients to access it.

The European Medicines Agency, the European equivalent of the FDA, also approved Kadcyla in late 2013. Despite its proven effectiveness, the UK's National Institute for Health and Care Excellence rejected coverage of the drug in 2015, citing its high cost as the primary barrier. It wasn't until 2017 that Kadcyla was approved for NHS coverage, meaning UK breast cancer patients had to wait four years longer than their American counterparts to receive this treatment. By the time Kadcyla was approved for NHS use, thousands of breast cancer patients who could have benefited from the drug had been denied access.

In Canada, only 11 percent of new cancer drugs that were approved for marketing in Canada, the United States, or the EU between 2016 and 2020 were listed on its public formulary. In contrast, in the United States it was 90 percent. Additionally, Canadian patients had to wait 1,835 days from the first new drug application to listing on public formulary, while U.S. patients only waited 486 days.

Research from the U.S. Chamber of Commerce found that from 2017 to 2021 the United States launched 83 new cancer active substances compared to 58 in Europe and the UK. A team of global health researchers also found that of the total number of cancer drugs globally launched between the years of 1990 and 2022, European countries only launched 10.5 percent of therapies, or 58 drugs. In comparison, the United States launched 257 cancer drugs, making up nearly half (45 percent) of globally launched therapies. If the United States were to adopt similar price control policies to that of the UK and Canada, early phase cancer research would be reduced by an estimated 54 percent.

Research shows that – when compared to the American health care system – single-payer systems have marked and consistent delays in care, fail to meet treatment standards, and suffer significant health provider shortages, all leading to lackluster care for patients with cancer, the second leading cause of death in the world.