Do Rx drugs cost too much?

Choices and consequences

By Mark Pauly, PhD

It is almost never possible to justify a high price for anything; once people agree that the price is high, they almost always agree that there must be something wrong. When it comes to prescription medications, however, I'm not sure that I would agree that the price is high.

A full page ad from a discount drugstore chain in last month's Philadelphia newspapers gave the prices for the 50 most common prescriptions. A few prices were a little above $100, but the great majority were less, and for some generic antibiotics the price was below $10. Last month I flew from Philadelphia to Boston and returned in the same day; my airfare was $506.50. Which price was high? Obviously, the answer to the question depends on the standard of comparison—which leads to the inescapable conclusion that the only thing we can be sure of is that no one can prove absolutely whether drug prices are high or not. We can only offer opinions, and those opinions depend on what we use as the basis of comparison.

For instance, we might compare drug prices in the U.S. with those in other countries. As my colleague, Patricia Danzon, has shown,* the prescription drugs look uniformly expensive here only if comparisons are made selectively, not if we compare a broad representative sample of drugs using proper price indexes. Another standard for comparison is to consider the profit rates of drug companies with those of other firms. Compared to Microsoft, drug company profits as a percentage of revenues or as a return on equity look low.

They do look somewhat higher than the typical accounting number for a Fortune 500 firm, but if we calculate profits correctly by including investment in R&D as part of equity capital and compare drug companies with firms in equally risky situations, as economist Henry Grabowski of Duke University has shown, the differences are small, if not nonexistent. Moreover, an ideal economy is not one in which consumers are happy.

The market needs a peace treaty

By Alan Sager, PhD and Deborah Socolar, MPH

Americans face two main prescription drug problems. Our prices seem to be the highest in the world and our use of medications is apparently below average for industrial democracies. The drug companies offer two lines of defense: U.S. prices are not higher. And if they are higher, it is good for us at best, or unavoidable at worst. These positions are contradictory.

Some manufacturers and researchers suggest that prescription drug prices are not higher in the U.S. They claim that private bargaining and price negotiations within a putative free market hold down prices here, effectively matching the power of the government regulations, price controls and parallel importing that reduce prices in other wealthy industrial democracies. These actions by other governments—along with patent laws—badly undermine free markets and any analyses of prescription drug policy that imagine free markets.

(Ironically, competition in the unfree U.S. market prompts private regulation: formularies that can restrict access to medications and distort physician judgment.)

Patricia Danzon found higher U.S. prescription drug prices by almost all measures.* And Danzon worried that if the U.S. exercised its market power to win lower prices, the drug companies would lack revenue adequate to finance development of new medications.

Indeed, in a 1994 issue brief, the Pharmaceutical Research and Manufacturers of America (PhRMA) asserted that U.S. consumers had no choice but to "bear the world's drug research burden." Conceding then that foreign governments had won lower prices, PhRMA posed three alternatives: 1) "refuse to sell to countries that regulate prices," 2) "charge the same [low] prices in all countries" and 3) "persuade other countries to abandon price regulation." Rejecting the first two choices, PhRMA preferred the third—but offered no mechanism.

Mark Pauly is a professor, health care systems, public policy and management, insurance and risk management and economics, with the Wharton School, University of Pennsylvania in Philadelphia.

Alan Sager is a professor and Deborah Socolar, a research analyst, at the Boston University School of Public Health. They are principals in the Access and Affordability Monitoring Project.
HEAD TO HEAD

Paul: Choices and consequences

because all firms earn profits that are equal to or below average. In addition to being required by logic, above-average profits for some firms in a market economy serve the useful function of signaling to firms and investors that consumers appear to want more of the same kinds of products that currently yield those profits.

For me, however, both as an analyst and a consumer, these comparisons are not the relevant ones. If drug prices are too high, we know the cause: Governments grant patents—legally protected monopolies—to new drugs, entitling their manufacturers to government-enforced protection from competition for years, even if there is some other company that could and would produce the same drug and sell it at some lower price. Patents are not a perfect shield, but they do help to protect higher prices and higher profits than would have occurred in their absence. Even in this cynical age, however, we do not believe that patents exist solely to provide corporate welfare; instead, they serve as devices to encourage research and development of innovative and useful products. Abolish or limit patent protection, and we would have cheaper drugs, but fewer of them.

The real question then is whether the higher profits patents permit do indeed bring forth the ideal supply of new products. That ideal supply is defined in part by comparing the total benefits expected from a potential new product and its expected cost. If the former exceeds the latter, we will benefit from having a new product, even if the prices needed to cover its cost are “high.” The relevant next question then is: Are current patent policies and the prices that follow from them calling forth new products whose benefits exceed their cost to the maximum extent?

The larger policy question is even more complex: Is the net benefit from the last new product that just cleared the profit hurdle greater or less than the net benefit from greater use of existing products that would occur if their prices were lowered?

I know what the first research questions ought to be: If prices were lower, what new products would not emerge? And, if prices were lower, how much additional use of drugs would there be and how much is that use worth? I also know that no one, either inside or outside the pharmaceutical industry, knows the answers to these questions—which means in turn that no one can claim to know whether prices are too high (justifiably or not).

One way to get some clues as to whether drug prices are too high is to imagine the consequences if they were lowered. I will rule out government price-setting as a method for price reduction, either for retail sales or in some universal national health insurance plan. Neither form of state intervention seems politically plausible at the present time.

One way to get prices down, at least for a larger part of a product’s life cycle, would be to shorten the period of patent protection or, through compulsory licensing, weaken the patent shield in some fashion. We know what the qualitative effect of such a change would be: fewer new products, and especially fewer new products for conditions for which the market is intrinsically small (the so-called “orphan” drugs) or fewer new products that require long periods of development in which investors’ capital is at risk. There may be better ways to reward and create incentives for new research—some economists, for instance, have suggested up-front prizes for good discoveries—but so far none has passed the laugh test.

Consider another way to lower prices: Require sellers of drugs in the U.S. to charge the same wholesale price as they charge in the rest of the world. This would cause prices to be higher abroad rather than lower here and lose international business for American drug companies and their workers. In any case, the effect of such a rule would be to reduce the total revenues the company can collect for its drug, since the reason it sells for less abroad is that if the price charged is considered too high, the foreign customer (usually a government or government-regulated health plan) is more willing to forgo the American product for a lower-quality alternative. There is, after all, no reason to assume that drug companies charge or accept prices abroad that are lower than what that market will bear, and the thought that they should ally with our government to wring yet higher prices out of foreign markets seems to me to be a mercantilist (and political) delusion. The punch line is that if drug companies are forbidden to use price discrimination in ways that bring in foreign sales so they can maximize their revenues, some drugs will not be brought to market—since the extra revenue from price-discounted foreign sales can be the difference that puts a product’s net revenue over the top.

We all wish we could have good drugs cheaper, both now and in the future. In our constrained world, however, we have to choose: We can have more good drugs or cheaper drugs, but not both.

If we had enough information, we might be able to tell whether, compared to what we would otherwise get, we might be willing to give up some brand new products in return for a somewhat lower price for recently introduced products. But, since we most certainly do not have that kind of information and are unlikely to get it without a major analytical effort, we need to be careful in advocating that something be done now about the high price of drugs.

What we wish for might just come true, but some of the consequences may be unintended and undesirable.
Sager/Socolar: The market needs a peace treaty

for such persuasion.

Denial of higher U.S. prices conflicts with PhRMA’s attempt to justify them as necessary to finance new medications. But these two conflicting positions share one desperate desire: to avoid action by federal or state governments in the U.S. that would reduce drug companies’ revenue.

The present price regime is unfair. Manufacturers’ average prices are higher in the U.S. Americans without insurance for drugs pay even higher prices. They must bear costs shifted by HMOs, hospitals, and others that win discounts. Independent and chain pharmacies also complain that they and their customers must pay more. This may help spur pharmacy closings, a trend that can reduce retail price competition and increase patient inconvenience.

The present regime endangers many Americans’ health. Given the effectiveness of many medications, our low use rates—possibly caused by high prices and gaps in insurance coverage—may be one cause of high overall U.S. health care spending. Preventable but costly hospitalizations could result from inability to obtain useful drugs at affordable prices, especially for people with low incomes. And disproportionate closings of pharmacies in minority communities, where pharmacists can provide valuable advice and medical triage, can make it still harder to obtain necessary medications.

The problem of high U.S. drug prices will only grow as new, effective and high-priced drugs are developed and marketed and as our aging population needs more medications.

The extra sums that Americans spend for prescription drugs above prices prevailing elsewhere—$12 to $35 billion extra yearly, we estimated in 1994 legislative testimony—constitute a huge covert foreign aid program, sanctioned by Congressional inaction.

The poor targeting of this aid is unrivaled. Its main beneficiaries are not starving or threatened people; they are the relatively well-to-do citizens of Sweden, Switzerland, Germany, the U.K., Japan and the other industrial democracies. Even the minimum estimate of the cost of this gift surpasses our nation’s overtly legislated foreign aid.

Americans could pay the world’s lowest drug prices since we exert the greatest purchasing power, expending one-quarter of the world’s dollars. But we pay more.

The U.S. government could marshal the public’s massive purchasing power to win lower prices. To prevent that, drug companies make campaign contributions. They try to deny that U.S. prices are extraordinarily high. And they threaten—as noted earlier—that vital new medications will not be developed unless Americans pay very high prices.

Today, PhRMA’s position is understandable. Its members do not see a practical foreign source of financing for their profits and research to offset any drop in U.S. prices.

Tomorrow, drug makers should abandon this position. They should press our government to launch international negotiations to win fair prices for prescription drugs by arguing truthfully that U.S. patients have long financed a disproportionate share of drug makers’ research costs and profits.

Manufacturers should do this because their excessive reliance on the U.S. market is unstable. Our subsidy of wealthy nations will not endure. Drug companies’ claims will, in time, be overwhelmed by an angry Congress or an angry series of state legislatures. Then—discredited and scorned—the manufacturers will find it much harder to replace the lost money than they would today.

Drug makers should act now, while their power is still high in many quarters, to urge international and public negotiation to establish a fair-pricing regime. There is precedent: Manufacturers support and participate in the International Conference on Harmonization, negotiating standards for scientific testing and approval of new drugs.

Negotiating a treaty to set fair prescription drug prices would be harder. First, it would have to set a desired level of total revenue for manufacturers. This would expose public analysis their research and marketing costs, and their profits. It would also make visible the current cost of their long-term and uncertain investments in better health. After learning that price, some nations might balk at paying it.

Second, the treaty would have to apportion most of the desired total revenue among the wealthy nations—in a way that replaced the income lost through lower U.S. payments—and also devise a way to get each nation to pay its fair share. Politicians elsewhere, anxious to slow growth in their own health care spending, would not race to embrace higher drug prices. But they need to be weaned from today’s welfare-like subsidies financed by American patients.

Third, price levels must be sensitive to each nation’s circumstances. They could be guided by these principles:

- Wealthy nations might bear most fixed costs of research, testing, production—and associated profits—and their share of variable production and distribution costs.
- Middle-income nations might bear a small share of fixed costs plus their share of variable manufacturing and distribution costs.
- Poor nations could be asked to pay, at most, variable costs for drugs. (These are usually relatively low.) When even these marginal costs exceed a country’s hard currency capacity, they could be divided among the wealthy nations.

The international prescription drug pricing treaty will be very difficult to negotiate. But the alternative—the inevitable disruption of today’s unstable and skewed financing—is more dangerous to drug companies, their stockholders and all patients who need effective and affordable new drugs.

Americans can enjoy both better and cheaper medications, once our government persuades other wealthy nations to pay their fair shares of manufacturers’ legitimate research costs and profits.