Price is a bitter pill to swallow

Rising drug prices have become a symbol for bigger problems.

BY RACHEL MELKER
Of the Post-Dispatch

Of all the pieces of healthcare spending, Americans are balking most at the cost of prescriptions.

Drugs represent only about 11 cents of every dollar spent to treat disease and stay healthy. Still, they have become a symbol for larger problems, because they are the most visible and frequently recurring health costs, said Steven Findlay, director of research at the National Institute for Health Care Management Foundation, a research and policy analysis group in Washington.

"For so many Americans, this is the expense they feel all the time. They've got to fill that prescription every 30 days or every 90 days, and some people are filling more than one," he said. "That's what has created this momentum (for change) and this very deep, grass-roots anger."

There are no simple answers. Few Americans question the overall value of most drugs. Paying for a daily pill makes more sense than allowing illness to progress until a patient needs costly and potentially dangerous surgeries and other procedures.

"There's a pricing premium on these (drugs), because they are things that people need. They are willing to pay for a drug that's life-saving," said Jim Golden, vice president of research at Framingham, Mass.-based Life Science Insights, a market analysis firm.

Bringing a medicine to market is not cheap or easy. Out of every 5,000 compounds that are screened, 250 qualify for preclinical testing, five of those make it to clinical trials and just one reaches consumers. Factor in the losers, and the overall cost to discover, develop, launch and market a single drug is about $1.7 billion, a recent study by Bain & Co. shows. The process takes about 12 years.

"We've come to think of medicines as expenses without considering the value," said Richard Manning, senior director of economic policy research for Pfizer Inc., the world's largest pharmaceutical company.

"Money can be saved by increasing spending on medicines, if they're taken right and preventively," he said. "I would really like to see the debate shift to what does illness cost us" rather than focusing on price.

Forty years ago, drug pricing wasn't an issue. Relatively few drugs were on the market. Most treated immediate ailments for a short time and were not a significant enough expense to warrant inclusion under the Medicare law when it was passed, said Joseph DiMasi, director of economic analysis at the Tufts Center for the Study of Drug Development in Boston.

The industry boomed in the late 1990s. Researchers developed pills that, if taken daily, could ward off or control chronic conditions that affect millions of people, such as high blood pressure, heart attack, digestive diseases and osteoporosis. At the same time, regulators allowed manufacturers to advertise these drugs, spurring demand.

See Drugs, G3

$0.4 billion

$0.3 billion

$0.2 billion

$0.1 billion

Drug Discovery

Pre-clinical testing

Phase 1 trials

Phase 2 trials

Phase 3 trials

Marketing

In millions of dollars

Sources: Tufts Center for the Study of Drug Development, Bain & Co. drug economics model

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Drug makers poll lower than cigarette makers

Continued from G1

Prescription prices, which historically go through cycles of boom and bust, rose at “unprecedented” rates from about 1998 to 2001, Findlay said.

The “blockbuster” drug — one with $1 billion or more in annual sales — was born. It became the industry’s driving force.

Discovery slowed, and sales volume flattened out, starting about two years ago. Patents expired and competition grew. Research became increasingly complex and expensive.

So, drug companies merged and acquired one another to obtain a blockbuster stable or pipeline. And they raised prices to maintain profits and increase shareholder returns.

Wall Street is demanding and cannot be ignored by the publicly held firms that develop virtually every drug that reaches consumers.

“The investors in the company want it to make money. So, if the company owns something valuable, they want the company to sell it for what it’s worth,” said Pfizer economist Manning. “That is, fundamentally, what drives all companies — the desire to benefit their shareholders.”

What it’s worth

Boosting financial returns did not elevate public esteem. In recent opinion polls, Americans ranked drug makers as low as tobacco companies.

Consumer skepticism has been fueled by recent headlines. Schering-Plough Corp. offered consulting fees to doctors who prescribed its brand-name drugs. Abbott Laboratories Inc. this spring quintupled the price of Norvir, an AIDS drug that had been on the market for years.

The companies also spend billions of dollars to advertise drugs directly to consumers, often without identifying the ailments. They sponsor physicians’ conferences and research. And they aggressively lobby politicians.

As a patent expires, the companies introduce reformulated or slightly improved brand-name versions of drugs. And they copy competitors’ innovations with “me-too” medicines, rather than researching untreated ailments.

Drugmakers have an answer for every complaint. They say the ads help educate patients and spark important medical conversations with doctors. The companies say if they didn’t tell doctors about their new drugs, the medicines would never be prescribed.

Manufacturers note that rivals often research the same ailment. They cannot predict, over a decade of development, which company will be first to market, nor should the loser be expected to abandon a promising product.

Some drug companies are responding to public concerns.

Pfizer recently introduced a program, which includes discount cards, to give uninsured people the same prices it offers to the insurance companies and bulk buyers that negotiate lower rates.

PhRMA, the industry trade group, would like to see all Americans in a government-sponsored insurance plan or guided to the cheapest retail outlets to avoid paying sticker price, spokesman Jeffrey Trefethen said.

“We understand the frustration of American patients,” he said.

Proving a drug’s worth

Public opinion and political debate have reached a tipping point. Even drug makers acknowledge that change is coming.

It is driven by fear that life-saving or pain-relieving drugs will be unaffordable, Manning said.

“I hope we can lessen the anxiety that’s out there and help people think about solutions that are less draconian,” he said, referring to proposals such as imposing price controls or reimporting drugs from other nations.

“If I don’t think there is a single thing that we could do, or that anyone could do, that would make things better overnight,” he said. If there were, “we would have done it.”

Still, there is a range of ideas to attack various legs of the complex process.

Within a few years, consumers, retailers, pharmacy benefit managers, insurers and the federal government alike will begin rejecting high prices on drugs that offer no novel benefit, predicts Findlay, with the National Institute for Health Care Management Foundation.

That already is occurring piece-meal in cases such as Nexium, the much-touted successor to Prilosec, which treats digestive ailments. After an initial boom in sales, insurers began telling patients they could have Nexium only if they paid a significantly higher share of the price. Once patients realized the therapeutic benefit was not worth the extra cost, demand fell, Findlay said.

“We’re pushing more of the cost back on patients to make them more cost-conscious,” he said. That’s good and bad, he said. It makes consumers more responsible but puts them at risk of not being able to afford a needed drug.

A more logical approach, Findlay said, is for the federal government to use a carrot-and-stick to push drug makers to prove a product’s worth. For example, if a company conducts head-to-head trials to show its drug is better than a competitor’s, then its patent could be extended. The results also would make choices clearer for patients, doctors and insurers.

DiMasi, of the Tufts Center, said the key is to empower patients with information. To make better economic choices, a medicine’s true benefit must be understood — both in terms of competitive benefit and the long-term effect on reducing overall health-care costs.

Other proposals focus on federal regulations, which may impose costly and time-consuming requirements on drug makers. The Food and Drug Administration is reviewing several policies and procedures with an eye toward streamlining.
Golden, of Life Science Insights, said the companies currently are reluctant to use new, efficient technologies during tightly regulated clinical trials, out of concerns they will spark lengthy reviews or rejected applications. Some also resist gathering as much data as possible, because they don’t want to uncover a flaw.

So, he said, the industry, perhaps with government should create “regulatory risk insurance,” a pool of money that could offset the financial risk to innovators. Once a technology has been tried and proven, it could benefit all companies.

Jackson Nicksen, associate professor of organization and strategy at Washington University's Olin School of Business, is working with the FDA and industry to examine manufacturing oversight. The current system encourages inefficiency, he said, which adds to production costs and feeds higher prices. Once the FDA approves a manufacturing process and specifications, making changes, even to improve efficiency or safety, can lead to lengthy, expensive regulatory review.

Streamlining could cut at least 15 percent, perhaps as much as 50 percent, from production costs, Nickerson said. “What is clear to me is that if you lower the cost, the price of drugs will come down.”

A fair share

Even that premise is subject to debate. The companies could cut costs to improve the bottom line without passing the benefit on to consumers. Some drug makers dispute that there is much fat, and say that cost savings could be passed along to company shareholders.

Such thinking has led analysts to believe that price controls may be the only way to go. Alan Sager, director of the Health Reform Program at Boston University School of Public Health, wants to cut prices, allowing more people to afford the drugs they need. The added sales volume would make up for lost revenue from lower prices, he said.

Others favor importing drugs from countries where government policies ensure that branded medicines cost less than in the United States. But most experts say that would be a temporary solution; manufacturers likely would restrict those countries’ supplies.

A better approach, Findlay said, would be for the U.S. government to make drug pricing a global issue. America should require its trading partners to pay more for medicines, shoring up an equitable portion of the cost of innovation.

That idea is supported by the industry. “Patients in other countries are not paying their fair share,” Trewirth said.

The industry also contends that much can be accomplished by encouraging greater competition at home in an open market. Drug companies would accept tougher negotiations from pharmacy benefit managers and bulk retailers, Trewirth said, to stave off government action.

Such negotiations are “the devil we know (and) have learned to live with,” he said. What’s more, insurers and retailers respect drug companies’ value as innovators. “So they’re not going to relentlessly go down that road” of price controls.

Drug makers say that if prices are capped and they can’t earn a profit, they will cut research and development. As a result, promising medicines might never be realized.

“These are perilous times for the drug industry, because of the increased likelihood that they could become faced with policy changes that would be very damaging,” DiMasi said. “People need to understand the economics of the system, that there is no free lunch here. Drug development is expensive, and someone, somehow needs to pay for it if we’re to have it continue.”

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National prescription drug expenditure

IN BILLIONS

- Total expenditures (including public funds)
- Total private expenditures
- Total private insurance expenditures

NOTE: First projected year is 2003

Source: Centers for Medicare and Medicaid Services

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