April 2000 Feature

What's behind high drug prices in the U.S.?

By Patricia Barry

The prescription drugs 78-year-old Lucille Danyow needs for breast cancer, high cholesterol and arthritis cost $870 for a three-month supply at pharmacies near her home in Vermont. Uninsured and unable to afford that much, she rides a bus 80 miles into Canada, where the same pills cost $470, nearly half as much.

In contrast, 81-year-old Mary Williams takes 10 pills a day for angina, hiatus hernia and other problems. But they cost her nothing. She lives in Britain, where medications are free for those 65 and over: There are no premiums, no copays, no caps.

The gulf between these two women, of like age but different geography, raises a key question in the current debate on prescription drugs:

Why do older Americans pay the highest drug prices but have the lowest insurance coverage of any nation in the industrialized world?

One obvious answer is that most Western nations have subsidized health-care systems that are government-run. Many Americans say they don't want the kind of restraints such systems require. And reports from Canada and...
Europe of higher taxes, overcrowded hospitals and months-long waiting lists for elective surgery do not warm Americans to those approaches.

A matter of location

The one American health system that is government-run and subsidizes a large chunk of the population, regardless of income, is Medicare.

For many older Americans in that group, the contrast with their counterparts abroad is most marked on the question of medications. In most European countries—as in Japan, Australia, New Zealand and Canada—older people pay little or nothing for prescription drugs.

This is because the cost of coverage and drugs is paid for by their governments. In the United States, where prescription drugs are not covered by Medicare, many older Americans are hit in one of two ways.

Those who are separately insured for drugs in private plans pay premiums that often rise as they become older and sicker and consume more drugs. Those with no insurance—and so without the price discounts people in health plans may receive—pay top dollar.

In both cases, drugs are a major expense of health care. Their price is therefore critical to the debate on coverage as Congress tries to figure out a way to help Medicare beneficiaries get the medications they need at a cost the country can afford.

Surging demand for drugs

When Medicare benefits began in 1965, prescription drugs were not included because at that time they were not as widely used nor as expensive as they are today.

But over the past 20 years, there has been a surge in new drugs—more than 600 in all, the industry says—to alleviate an ever-widening range of diseases.

Demand for them has driven up health spending. As Alan Holmer, president of the Pharmaceutical Research and Manufacturers Association of America (PhRMA) often says: "Seniors want
access to our medicines because they were invented."

About half of Medicare's 40 million beneficiaries have access to drugs through a year-round level of private insurance coverage, according to a recent study released by the Commonwealth Fund. But another 8 million have inadequate coverage and 12 million have none.

How those older Americans cope is summed up by Richard Davis, a Vermont consumer health activist and a home-care nurse: "Sometimes they don't fill their prescriptions at all because they can't afford to," he says. "Or they stretch out the prescription, so they're only taking half as many pills as they should be.

"The inability to afford drugs and the anxiety over it," he adds, "become part of their illness."

Drug prices keep rising: an average of 5.7 percent in 1999, as measured by the Consumer Price Index, or more than twice the level of inflation.

This is why some uninsured Americans, such as Lucille Danyow and her breast cancer support group, cross the border into Canada where retail drug prices, as in other Western nations, are far lower than in the United States.

**The industry's position**

PhRMA, which represents the pharmaceutical industry, says it wants Medicare beneficiaries to have more insurance coverage—preferably by government subsidies on premiums to help them buy private plans.

But it shows no inclination to lower prices. The legislation it opposes most vigorously, a bill sponsored by Rep. Tom Allen, D-Maine, would allow Medicare to negotiate drug price discounts for all beneficiaries.

The industry believes that enacting this bill, or President Clinton's proposal for a Medicare drug benefit, would lead to its worst nightmare—government regulation.

Price controls, says Alan Holmer, president of PhRMA, would "create an environment that is extremely adverse to research and innovation.
and would have a very bad impact on the ability of the companies to continue to bring those medicines to market."

Controls would especially affect research for patients "who are waiting for cures for Alzheimer's, Parkinson's and other conditions" that hit older people hardest, he adds.

This argument is central to the drug makers' position in the debate.

In fact, it is an argument the industry has mounted twice before: in 1984, when Congress made cheaper generic drugs more available and better able to compete with brand-name drugs; and in 1990, when it allowed the states to negotiate lower prices for Medicaid.

Yet research continued to grow after both measures took effect. According to PhRMA's own figures, from 1985 to 1990 the companies' annual investment in research and development (R & D) doubled from $4.1 billion to $8.4 billion. After 1990 it tripled, to $24 billion in 1999. The projection for 2000 is $26.4 billion.

The cost of developing medications is huge—more than $500 million per drug, the industry says—with no guarantee that all will survive clinical testing. "Few drugs even cover their development costs," PhRMA notes. "Companies rely on highly successful products to fund R & D."

The industry says it spends 20 percent of its revenues on R & D. It also makes high profits. Among Fortune 500 companies, the pharmaceutical firms' median profit was 18.5 percent return on gross revenues in 1998. Their nearest competitors were commercial banks at 13.2 percent, with all other industries trailing at a median 4.4 percent.

**Another point of view**

"The drug companies give the impression that they need those profits to fund R & D," says Stephen Schondelmeyer, an expert on pharmaceutical economics. "But no, that's not true. The 18.5 percent profit is accounted [for] separately from the 20 percent they say they spend on R & D."
Schondelmeyer, a professor in the University of Minnesota's College of Pharmacy, constantly tracks drug company activities through their annual reports, Fortune 500 statements and other public accounts.

He translates that information into a rough breakdown of what we pay for when we buy drugs.

"On average, for every $100 spent on a drug at the manufacturer's level, the actual cost of making it is about $10 to $15," Schondelmeyer says. "A further $20 goes to R & D. About $15 goes to taxes and administrative costs. About $30 goes to advertising and marketing. And about $20 is profit."

"So we have to ask ourselves: What are high prices funding?" he adds. "In part they fund R & D, but a lot more goes into marketing and advertising. Do seniors intend to contribute $30 in every $100 drug bill to that? Do they have any choice?"

The cost of political lobbying is included, too. The industry spent $148 million on lobbying in 1997-98, reports the Center for Responsive Politics, which tracks political contributions.

"So every time senior citizens buy drugs," Schondelmeyer says, "they're funding that lobbying effort, which is often advocating things that work against their best interests."

With so high a profit, couldn't the industry afford to lower prices? PhRMA says no: "Without reasonable returns on R & D investments, companies will not attract the investment capital needed to fund ongoing research to discover and develop new lifesaving, cost-effective medicines." About 600 such drugs are in the pipeline, it says.

Schondelmeyer disagrees. "They've got a long way to go before a major profit impact makes them less attractive to investors." Also, he says, "No CEOs would start by cutting R & D if they're squeezed. They'd first cut marketing and advertising."

The debate over volume
One aspect of the industry's opposition to lowering prices especially puzzles health economists. A free market, which the industry says it supports, is usually driven by volume.

So wouldn't a drop in prices—in the form of discounts for the Medicare market—be offset by increased purchases of drugs by people who at present can't afford to buy them?

"We have no confidence that would be the case," says Holmer of PhRMA.

The investment firm Merrill Lynch, on the other hand, thinks it might. Giving all Medicare beneficiaries a discount of as much as 40 percent, it calculated last year, would reduce the industry's total revenues by only 3.3 percent, because of increased sales. A discount of 15 percent to 20 percent would, for the same reason, actually raise revenues by 1.3 percent. That "may not be so bad" for the industry, the report concluded.

The Merrill Lynch analysis assumed that the volume of sales would go up by 45 percent among those beneficiaries currently uninsured. In practice, it could be less. But the principle of volume driving the market is upheld by economists.

"This is really Economics 101," says Uwe Reinhardt, professor of health economics at Princeton University. "You get less on each item but make it up on more items. That's always been the case.

"I'd argue that doctors and hospitals would have a lot less money every year if Medicare hadn't come along. For them, Medicare was a boon, and so it will be for the drug companies."

PhRMA's lobbying resources are being stretched these days. Even as it tries to fend off the federal bills it most dislikes in Washington, it has had to scramble around the country to lobby against sometimes more draconian bills in several state legislatures.

These states have recognized the advantages of bulk-buying drugs for older citizens.

It is a strategy other Western countries have pursued for decades. Since 1948, for instance, a
single British government agency has negotiated prices with drug makers on behalf of the country's 59 million citizens.

The Association of the British Pharmaceutical Industry (ABPI) says, with some pride, that it has "reduced prices in real terms by 14 percent since 1990."

**British experience**

Yet the British industry invests the same proportion of its revenues into R & D as the United States: 20 percent. And while it nowhere matches the U.S. in innovation, Britain still developed five of the world's current 25 top-selling drugs, compared to the American industry's 16.

How does it do this if, as PhRMA maintains, price controls stifle the industry? One reason may be that Europe forbids direct-to-consumer drug advertising. Britain allows drug makers to spend no more than 9 percent of revenue on advertising to health professionals.

How about profits? "We make a fair profit," says Ben Haynes, ABPI public affairs director, explaining that companies are allowed up to 21 percent profit on drugs sold within Britain.

But that is not the whole picture. "While the home market is solely price-controlled, we also export 50 percent of our products." That is where a healthy chunk of profits comes from, he says.

Many of these exports—as well as drugs from other price-controlled nations—are sold to the United States, where the highest prices can be charged. In other words, says Alan Sager, a professor at Boston University's School of Public Health, "Americans are subsidizing the citizens of other wealthy nations."

As to how regulation abroad affects consumers, Holmer of PhRMA says: "Price controls don't work."

He criticizes Canada, citing its system of "mandated drug switching" (substituting cheaper products), "gatekeepers" who review which drugs will be approved for the formulary (the list of drugs available to patients) and patients forced to use medicines selected for cost
reasons.

Point counterpoint

But, says Schondelmeyer, all this happens in the United States, too, within private HMOs.

"The private health plans review which drugs are going to be put on the formulary and mandate the switching of drugs," he says.

Schondelmeyer points out that prices in every part of the U.S. health-care system—like physicians' fees and hospital charges—are already controlled, except drug prices. Under any Medicare drug benefit, he says, the rules "must pay attention to price levels.

"Otherwise it would be the same as Congress writing a blank check to the pharmaceutical companies to set their price. And we'll pay it."

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