

Chapter Eighteen

Prescription Drugs

MYTH NO. 18: SINGLE-PAYER NATIONAL HEALTH INSURANCE WOULD REDUCE THE COST OF PRESCRIPTION DRUGS FOR AMERICANS

Advocates of single-payer insurance maintain that it would simultaneously: (1) provide all Americans with full coverage for necessary drugs and (2) contain drug costs. They say it would do so by establishing a national formulary—a list of drugs available to patients under the national health program—and by negotiating drug prices with manufacturers “based on their costs (excluding marketing or lobbying).”¹

These ideas appeal to many Americans facing high prescription drug costs. However, access to new, more effective drugs is often restricted in countries with national health insurance. Furthermore, although some drugs cost less in other countries, other drugs cost more. Studies in the mid-1990s showed that U.S. prices were not necessarily higher than in other developed countries, nor was per capita spending on drugs. Recent updates of those studies show somewhat higher prices in the United States, but international prices are very similar, relative to average incomes. U.S. per capita spending now exceeds that of most other countries, but that may not be a bad development, especially if drug therapies are substituting for more expensive hospital and physician therapies. In fact, evidence suggests that at least for the elderly we may be spending too little on drugs.

WHY NEW DRUGS ARE SO COSTLY

Pharmaceutical companies that develop new drugs have an exclusive right for a limited number of years to manufacture their product under U.S. patent laws and international treaties. Patents allow drug makers to recoup their costs, and encourage companies to take the financial risk of drug development. Only one in five drugs tested ever reaches the market, making drug development very costly, now averaging about \$900 million for each new drug.² Further, once patent protection has lapsed, any rival company can manufacture and sell a generic equivalent. At that point, the price tends to equal production costs alone, regardless of the original costs of development.

PRICE CONTROLS

We saw in chapter 13 that some advocates of single-payer national health insurance are envious of the ability of governments in other countries to exploit their monopsony bargaining power to push down the fees of doctors and other health workers. A similar principle applies to drugs. If manufacturers have to bargain with a single entity, acting on behalf of an entire country, they are at a severe disadvantage.

A government facing continual crises of rising health care costs is tempted to insist on prices just above the costs of production, ignoring all the R&D costs. Thus, the country could try to reap the benefits of new drugs without sharing in the expense of their development. When push comes to shove, pharmaceutical companies are tempted to give in to such demands, since the development costs are sunk costs. They may conclude that as long as they cover the costs of production, something is better than nothing.

However, if every country in the world were to follow this strategy and succeed, no one would be left to pay for R&D. That means no new drugs. Some policies that seem smart from a purely local point of view can have disastrous consequences internationally. Politicians in other countries want the United States to pay all the development costs while they reap the benefits. Single-payer advocates in this country overlook the fact that if the United States followed the same strategy, there would be no one left to pay for R&D.

Countries with less money to reinvest in R&D have seen their pharmaceutical industries decline or go abroad. The United States, which has no widespread price controls, produces far more drug innovations than any other country.

DO EUROPEANS HAVE ACCESS TO THE SAME DRUGS AS AMERICANS?

One way OECD countries control drug expenditures is by delaying the market-place introduction of the newest drugs or by restricting access to them. To speed access to new drugs, the European Union took steps to centralize the process for marketing authorization through the European Agency for the Evaluation of Medicines in 1995. However, drug companies must go through additional steps in order to make their drugs available to patients. After a drug is approved by the EU, drug makers must negotiate the selling price with each national government. And, finally, they separately negotiate the “reimbursement rate,” or subsidy, provided by the EU to the drug companies for important new drugs. Until all these hurdles are cleared, new drugs are unavailable to most patients.³

Because of these barriers to entry, patients in some European countries wait months or even years longer than patients in America for access to new medications, including breakthrough drugs. For instance, according to studies by Europe Economics, a London-based research organization,⁴

- A major new medication that treats the nervous system was not accessible to patients for three additional years in France and nearly six years in Portugal after its introduction in the United States.
- An important new anti-infection therapy already available in other EU countries was not accessible to patients for three years in Belgium and France and for more than four years in Portugal and Greece.
- A new cardiovascular drug available in other EU countries was withheld for almost three years from patients in Portugal, Spain and Greece.

ACCESS TO DRUGS IN BRITAIN

In Britain, many drugs that are available to private pay patients are not available to NHS patients. Each local health authority can decide which drugs are placed on its formulary, and due to budget limitations, expensive drugs are often left off the lists. As a result, NHS patients are often denied the best drug therapy. For example:

- Dr. Edward Newlands, the British doctor who codeveloped the brain cancer drug Temodal, cannot prescribe it to his patients.⁵
- Taxol, a drug that is widely prescribed in the United States for the treatment of breast cancer, and Gemzar, a drug used to treat pancreatic cancer, are unavailable in some regions of the United Kingdom.⁶

- Fewer than one-third of British patients who suffer a heart attack have access to beta-blockers used by 75 percent of patients in the United States, despite the fact that post-heart attack use of the drug reduces the risk of sudden death from a subsequent heart attack by 20 percent.⁷

Recall also the conclusion of a WHO study that lack of access to the best cancer drugs costs the lives of 25,000 Britons every year.⁸

ACCESS TO DRUGS IN CANADA

In recent years the news media have featured stories about buses heading to Canada loaded with Americans in search of cheaper Canadian drugs.⁹ What many people may not have heard is that some Canadians travel to the United States to buy drugs not available at any price in Canada. For example, one of the newest drugs to treat noninsulin dependent diabetes—Glucophage XR—is not available in Canada.¹⁰ Canada tries to control drug costs through price controls and provincial formularies. Manufacturers are allowed to charge higher prices for new drugs that the federal Patented Medicines Price Review Board decides are a substantial improvement over existing drugs. Of the 581 drugs reviewed between 1988 and 1995, only 41 were allowed to earn a higher return.¹¹ From 1994 through 1998 the board approved only 24 of the 400 drugs considered, ruling that the rest were not substantial improvements over their predecessors.¹²

In addition, each of Canada's ten provinces has a review committee that must approve the drug for that province's formulary, which determines which drugs will be paid by the health program. A drug may be approved by one province, but not another. For instance, of the twenty-three cardiovascular drugs approved by the national government between 1991 and 1998, one province covered only ten while another covered twenty-three.¹³

Approval times for additions to formularies vary greatly from province to province. For instance, while Nova Scotia approves drugs for its formulary in 250 days, it takes nearly 500 days in Ontario.¹⁴ In theory, Canadians can buy any federally approved drug, even if it is not on the provincial formulary, by paying for it themselves. However, drug companies often don't market those drugs widely because the demand is so low.¹⁵

A University of Toronto study concluded that the main effect of price controls has been to limit patients' choices, causing them to rely more on hospitals and surgery.¹⁶ British Columbia has gone farther than most provinces in controlling access to new drugs. Under its "reference price system" it can require that a patient receiving subsidized drugs under the provincial health

program be treated with the least costly drug, even if it is a completely different compound, as long as it is deemed to have the same therapeutic effect. Since the effectiveness and side effects of drugs vary from patient to patient, frequent therapeutic substitution has harmed patients.¹⁷

- 27 percent of physicians in British Columbia report that they have had to admit patients to the emergency room or hospital as a result of the mandated switching of medicines.
- 68 percent report confusion or uncertainty in cardiovascular or hypertension patients, and 60 percent have seen patients' conditions worsen or their symptoms accelerate due to mandated switching.

Dr. William McArthur, former chief coroner for British Columbia, recalls from his own practice a sixty-four-year-old male patient who had controlled peptic ulcers for more than five years. When the government required that he be switched to an older, less effective drug, within three days he required hospitalization and a lifesaving blood transfusion. After ten days in the hospital and several more transfusions, he was discharged and placed on the drug he had taken originally.¹⁸

ARE PRESCRIPTION DRUG PRICES LOWER IN OTHER COUNTRIES?

Comparing prices across countries is complicated. Pharmaceutical companies, like makers of other products, charge different prices in different countries. In the United States, the list prices of drugs are generally used as reference points for calculating discounts and are not usually the price actually paid. Also, the top-selling drugs in one country are not the top sellers in others, so one cannot simply compare top sellers. Further, generic drugs often have higher volumes and lower prices than brand-name drugs.

Economist Patricia Danzon examined some well-publicized international price comparisons of pharmaceuticals and concluded that their findings of very large price differences between the United States and other industrial countries were based on flawed methodology. Among the errors: using small, nonrandom samples of products, excluding generic drugs (which make up 42 percent of U.S. purchases), ignoring differences in prescription and consumption patterns from country to country, and ignoring manufacturer discounts and rebates in the United States.¹⁹

Professor Danzon conducted her own comparison, attempting to control for all these complicating factors. She determined the manufacturers' prices

for both brand-name drugs covered by patents and generic drugs in the United States and eight other countries, and converted the weights of each product to U.S. measures. Depending on the country and the drugs available, she compared from 187 to 484 products. She found that average prices of prescription drugs were comparable to or higher than U.S. prices in Canada, Germany, Sweden and Switzerland, and lower in France, Italy, Japan and the United Kingdom.²⁰

More recent research by Danzon found that due to the recent weakness of the Canadian dollar, the relative prices of Canadian medications fell compared to the United States. Further, drug prices in Italy, Britain and Germany were approximately 15 percent lower (or less) than in the United States while prices in France and Canada were about 33 and 30 percent lower, respectively. However, for most countries, the prices charged reflect differences in living standards and national income. When these variations are taken into account drugs cost less in the United States than in the other countries surveyed, except in France.²¹

HOW SUCCESSFUL ARE PRICE CONTROLS AT HOLDING DOWN DRUG SPENDING?

Apparently not very, despite the fact that countries with single-payer systems try to limit both price and availability. OECD data from 1992 showed that when per capita spending on medications was adjusted for differences in the value of currency from country to country (“purchasing power parity”), the United States spent less than France, Germany and Japan. It spent a few dollars more than Canada and substantially more than Britain. More recently, spending in the United States has inched up relative to other countries, possibly because managed care organizations seized opportunities to substitute drug therapies for more expensive doctor and hospital therapies during the 1990s. Figure 18.1 shows the following:

- France spent \$290 per capita on prescription drugs each year, compared to \$283 for the United States.
- Spending in Japan (\$281) was only slightly less than in the United States.
- Trailing these countries were Germany (\$255), Canada (\$237) and Britain (\$162).

Note that if the greater U.S. spending in the 1990s is a result of the substitution of drug therapies for more expensive ones, this change represents an increase in efficiency.

FIGURE 18-1

A Comparison of Pharmaceutical Expenditures per Capita



Note: Based on purchasing power parity, U.S. dollars. Data are for 1997. Pharmaceuticals include nonprescription products.

Source: *OECD Health Data, 2002.*

DOES PRESCRIPTION DRUG SPENDING SAVE MONEY?

Despite its high cost, we are getting quite a bit of value for our investment in drugs. Drug therapy is one of the most efficient methods of treating disease. In many cases, drug therapies have reduced the cost of other health care services. Even greater savings are possible because in many cases newer drugs are more effective than older, less expensive drugs.

Research by Columbia University professor Frank Lichtenberg indicates that each dollar spent on drugs is associated with roughly a four-dollar decline in spending on hospitals.²² Furthermore, a reduction in the age of drugs (substituting newer for older drugs) reduces spending on hospitalizations and doctor visits by 7.2 times as much as it increases drug expenditure. The number of hospital stays, bed days and surgical procedures declines most rapidly for those diagnoses with the greatest increase in the total number of drugs prescribed and the greatest use of new drugs.²³

Overall, Lichtenberg's estimates imply that an increase of 100 prescriptions is associated with 1.48 fewer hospital admissions, 16.3 fewer hospital days and 3.36 fewer inpatient surgical procedures. He also estimates that new drugs have increased life expectancy by as much as 1 percent per year.²⁴

SHOPPING FOR DRUGS

Patients whose drugs are paid for by a third party (a private insurer or government) have little incentive to shop for the best price. This is especially true in countries with controlled drug prices, where there is no price competition. American consumers, however, can significantly lower their drug costs by comparison shopping among American pharmacies, buying medications in large quantities and splitting double-dose pills.²⁵

Using these techniques, in many cases patients can obtain drugs at lower prices in the United States than they could by purchasing them in Canada. For example, the *New York Times* compared U.S. and Canadian prices of ten drugs widely used by seniors. They found in all ten cases Canadian prices were lower. But they didn't look very far, and they didn't investigate shopping techniques that would be normal for any other consumer purchase. The National Center for Policy Analysis compared the Canadian price to the best price consumers could obtain using smart-shopping techniques. Table 18.1 shows the following:

- For seven of ten drugs, U.S. buyers can lower their costs an average of 38 percent below the price charged in Canada.
- For all ten drugs combined, smart buying in the U.S. produces an average cost of 10 percent below buying in Canada.

TABLE 18-1

Smart Shopping Versus Canada

Drug	Condition	Dose	Qt.	Best Canadian Price	Smart Shopping Cost	Smart Shopping Saving
Lipitor	High cholesterol	20mg	30	\$60.66	\$45.00	26%
Norvasc	High blood pressure	10mg	90	\$153.66	\$167.32	-9%
Paxil	Depression	20mg	30	\$57.20	\$40.86	29%
Premarin	Osteoporosis	0.625mg	100	\$25.75	\$77.90	-203%
Prevacid	Ulcers	30mg	30	\$69.63	\$21.42	69%
Synthroid	Hypothyroidism	0.05mg	100	\$19.77	\$10.83	45%
Toprol-XL	High blood pressure	100mg	90	\$35.51	\$17.00	52%
Zithromax	Antibiotic	250mg	6	\$31.38	\$41.95	-34%
Zocor	High cholesterol	20mg	30	\$67.43	\$54.30	19%
Zoloft	Depression	50mg	30	\$45.54	\$33.33	27%

Note: Based on National Center for Policy Analysis survey of pharmacy Web sites in Canada and the United States conducted in July 2003.

NOTES

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