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## This Doesn't Have to Be the Price We Pay

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As Congress moves toward a seemingly inevitable plan for prescription drug coverage for the 40 million senior citizens covered by Medicare, a central question has been overlooked: What should those drugs cost?

If the question seems curious, consider this: While the price of drugs is unregulated in the United States, every European nation controls them. The Medicare system, which has roughly the same population as Spain, should do the same.

The Europeans use their entire populations as a cohort -- a large group of patients with a common need -- to compel drug manufacturers to charge far less there than they do here. It is essentially a take-it-or-leave-it approach, and it's not surprising that the drug companies have decided to take it. That's good news for Europeans, but bad news for us. While the drug companies are forced to sell close to the margin elsewhere, they make up the difference in the American market, inflating our drug prices by a further 2 percent to 3 percent per year, according to IMS Health, a market research firm in Fairfield, Conn. As a result, their profits are decreasing there and increasing here.

France, Italy and Spain use direct price controls, limiting prices at the launch of a product and later controlling the amount of reimbursement once the drug is on the market. Spain and Britain limit profitability on a drug-by-drug basis.

The House Committee on Government Reform, in a 2001 report on prescription drug prices, found that as a result of controls, such drugs cost 31 percent to 48 percent less in Canada, France, Italy, Britain, Germany and Japan than in the United States. Critics of price controls maintain that the incentive for research and development will be lost without competition and free enterprise, but this is hardly a concern in the current climate of me-too drugs, where new duplicate drugs that lower blood pressure or cholesterol or soothe the stomach compete with older, satisfactory products in the same class. No one would suggest that there should only be one drug to treat a given disease or symptom, but the current amount of duplication is excessive -- and expensive.

When asked why pharmaceuticals cost so much, the drug companies often point to the high cost of that R&D. What they don't say is that they also spend an inordinate amount plying physicians with free lunches and over-packaged sample products. Or that they overspend on expensive advertising aimed at patients. (In fact, the industry's advertising costs exceed its R&D costs!) With a blockbuster drug, it's not unusual for a manufacturer to budget \$50 million to \$100 million for advertising aimed at consumers, according to Rx Insight, a consulting group that advises drug companies. In 2000, Pfizer spent \$89.5 million advertising Viagra to consumers.

The United States and New Zealand are the only countries in the world that don't ban direct-to-consumer pharmaceutical advertising. Western Europe saves billions of dollars by not allowing this questionable seduction. Every day I treat patients who ask me for a drug they've seen on TV or in a magazine, and

according to recent surveys by the Food and Drug Administration and by Kaiser Permanente, that's become the norm: Between 20 percent and 30 percent of consumers who view a drug ad ask their doctors about the product they've seen.

Restricting the pharmaceutical solicitation of doctors and eliminating advertising aimed at patients would likely decrease the popular pressure that supports inflated prices and unnecessary drugs.

Price controls, which the Bush administration opposes, would help the Medicare system gain lower drug prices, but why stop there? Congress should also change the laws that prohibit the importation of prescription drugs from other countries, where they are less expensive. The Senate on Friday endorsed importation from Canada; the House should follow suit. Such cross-border buying is one of the main reasons drug prices in Europe remain low. Across the continent, pharmacies import drugs from other countries that have negotiated a lower price.

France, for one, has successfully negotiated prices that are as much as 15 percent lower than those suggested by manufacturers for the stomach medicine Prilosec (made by AstraZeneca), the cholesterol-lowering drug Lipitor (Pfizer) and the top-selling antidepressant Paxil (GlaxoSmithKline). In the United States, Lipitor, which brought Pfizer revenues of \$8.6 billion last year worldwide, costs \$2.38 per 10 mg tablet wholesale -- that is, the cost to pharmacies. The same pill is sold to French pharmacists for 75 cents. It costs 93 cents in Britain.

The major drug companies have tried to resist controls but have been largely ineffective in dictating European prices. From time to time, they threaten not to supply the drugs, but that never happens. Last year, several of the world's biggest drug companies, hearing that Germany's Health Ministry was planning to impose a 4 percent price cut on prescription drugs, collectively donated almost \$200 million to Germany's state-sponsored health plan with the express goal of staving off the reduction. Germany took the subsidy yet went ahead with the price cut anyway, and because 80 percent of prescription drugs in that country are purchased by the public health insurance system, the drug companies had no choice but to accept it.

The idea that Medicare would name the price it is willing to pay for something is not entirely foreign. Medicare already dictates doctors' fees and laboratory and hospital reimbursement. Under the current system, doctors have an option. We can be Medicare providers and accept that the prices the government decides are fair and reasonable, or we can go outside the system entirely and not accept Medicare at all. If we choose the latter, our elderly patients will not be reimbursed for our services. We can charge top dollar, but then many patients would not be able to come to us. We will survive outside the system if we provide an exclusive service that is in high demand. This "loophole" is what makes the current system legal. Doctors and hospitals don't have to accept these scaled-down prices, and our patients don't have to go to places that participate. But if either side chooses to decline the system, the payment is made out-of-pocket. The same logic would apply to drug manufacturers.

Extending this system to include the new prescription drug benefit would go a long way toward keeping drug prices down. Medicare could decide which drugs are duplicates and which have generic equivalents. If patients want a drug that is not covered by Medicare, they could pay for it. If a drug company brings to market a product it perceives to be exceptional and not simply a duplicate of what exists, then that company will have the option to go outside the system and charge full price. The overall effect will be the savings of billions of health care dollars.

Drug companies will grumble, the way doctors already do. Yet most doctors still choose to play ball with Medicare, and so will the drug companies. The reason is that the Medicare client base is so large

that most providers -- whether doctors or manufacturers -- can't ignore it and still stay in business.

Europe accounts for just over 20 percent of the pharmaceutical industry's more than \$400 billion world market, according to IMS Health. The United States accounts for 46 percent. But with our unregulated practices, we're the source of more than 60 percent of the industry's profit. We're filling its coffers; we should use our influence to dictate prices. After all, the current \$400 billion plan for Medicare prescription drug coverage can buy a lot more drugs at the prices Europeans pay for them.

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