



WARNING: HEALTHCARE PRICE CONTROLS ARE DANGEROUS TO YOUR HEALTH



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By Adam Brandon & Stephen Moore

Almost all Americans want lower price prescription drugs, and it is indefensible that American consumers often have to pay higher prices than customers in developed nations around the world. This is especially intolerable given that most of the wonder drugs of recent years and decades that we pay more for have been developed on these shores.

The Health and Human Services Department reports that a senior who receives an eye medicine that currently costs Medicare \$1,800 a month is only charged \$300 a month in many other nations. A popular chemotherapy drug Costs Medicare \$4,700 for each treatment here in the U.S. but only \$1,100 in other nations. The rest of the freeloading world is like the 25-year-old kid living at his parents' house rent-free and eating everything in the fridge. Something is seriously wrong here.

The solution is NOT to import other nations' price controls into our system. This is the latest flawed idea in healthcare policy making the rounds in Washington. It is what is known as international reference pricing for prescription drugs. The idea is essentially this: the federal government should impose price controls on pharmaceuticals in the United States based on price controls found abroad in order to save patients money and reduce the cost of programs like Medicare and Medicaid. An analysis of the underlying economics of such an idea quickly reveals not only the obvious problems with price controls. Price controls are particularly risky in the area of life-saving or therapeutic drugs because the price limits discourage innovation and development of new drugs that could accelerate the race for the cure for cancer, heart disease, MS, Alzheimer's, and many other killer diseases. If the profits are drained out of the system, the incentive for new drug development will be stalled.

Medicine is a complicated business with almost incomprehensibly complicated insurance and government (Medicare and Medicaid) rules for setting prices for different categories of customers, but that doesn't mean economic forces influence medicine any differently than any other industry producing things people want or need. As with any other laws, people try to break all these iron laws of economics all the time. Around the world -- and, unfortunately, this includes America -- politicians are championing "free" or socialized healthcare and other forms of government central planning in medicine that totally ignore the laws of supply and demand. But

when you break the law, you always pay a price. The price of “free” or socialized medicine is quite steep.

Socialized medical systems with price controls present a whole host of problems, from massive costs to taxpayers to reduced access for patients. The Congressional Budget Office (CBO) recently acknowledge this in a letter on options for socialized medicine that was requested by House Budget Committee Chairman John Yarmuth (D-Ky.). “If the number of providers was not sufficient to meet demand,” the CBO explained, “patients might face increased wait times and reduced access to care.”¹ Access problems are replete in nations with socialized medicine. However, these horrors and all things in between can all be traced back to how these policies influence supply and demand.

On the demand side, most government interventions in healthcare aim to do one thing: keep people from spending their own money. The only thing this approach really helps is the politician’s chance of getting re-elected. The impact on demand is the same, regardless of the chosen approach. Whether the government subsidizes private insurance or runs the entire healthcare system as a giant monopoly, they all work like price controls from the patients’ perspective because less money is leaving their pockets when they receive care – though they pay the difference through higher taxes or worse quality of care.

When the cost of medical care is either fixed or eliminated, patients will demand more because they don’t have to pay for it themselves. People eat more indulgently and waste more at an all-you-can-eat pre-paid buffet than if they have to pay for everything themselves.

One problem with below-cost health care is that the same resources used to provide absolutely necessary care are also consumed by those who receive more treatment than necessary or do not take adequate care of themselves because they lack the additional financial incentive to better manage their health. They also lose the incentive to put aside money for future healthcare needs with the expectation that the insurance company or government will cover their expenses. When patients’ price exposure is controlled, their cost-benefit calculations are thrown off. Why not get that extra test or treatment? It won’t cost you anything extra. Thus, demand goes through the roof.

Yet simply controlling what price a patient pays for medicine or other medical care does not change the cost of providing said treatment. There are enormous resource costs to providing healthcare, from the years and years of education and training doctors receive to the billions of dollars drug companies spend to develop new products and get them through the onerous and tedious approval process of the Food and Drug Administration (FDA). A new drug can cost hundreds of millions of dollars, and in many cases billions of dollars of investment funding. When patients

¹ <https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf>

demand more and consume more, something has to make up the difference between what the patient pays, which may be zero, and what it actually costs to provide whatever treatment they are receiving.

In the United States, this problem is manifesting itself as runaway healthcare price inflation and massive spending and structural deficits for the nation's main single-payer healthcare programs, Medicare and Medicaid. The chart below shows the rising inflation of health care costs versus other key industries. Most consumer industries have held prices down to very low rates of inflation and even falling prices – as in computers and textiles. Not so in health care. The semi-private insurance system in the United States has staved off the worst effects of price shielding. This is because private insurance companies have an incentive to negotiate prices but cannot force healthcare providers to accept otherwise unacceptable prices. In addition, patients with private insurance are given some skin in the game. Patients pay premiums and usually share costs with the insurance companies that are directly tied to their consumption of healthcare. While the price they pay is subsidized, and can reach zero in some circumstances, patients are at least somewhat price responsive in our system, although this can certainly be improved.

Medicare and Medicaid reimburse hospitals and other health care providers, such as drug companies, by discounting from the prices charged in the private sector. Patients on Medicare or Medicaid can still generally count on a high level of access to care but these programs have sometimes faced service constraints or budgetary constraints that can prevent patients from getting the highest levels of care. Medicaid reimbursement rates are so low that many top medical facilities – such as Mayo Clinic – do not take Medicaid patients. Both Medicare and Medicaid face an increasing problem of doctors simply not accepting new patients covered under the programs due to high levels of demand combined with low reimbursement rates.²

Medicare can only get away with offering low (and sometimes below cost) reimbursement rates by providers shifting some of their costs to private insurers. One problem with “Medicare for All” is that if everyone were paying Medicare's reimbursement rates, the health care system would collapse, because there will be no private sector insurance market to cover the costs.

All of this comes at a time when Medicare and Medicaid already consume enormous and growing shares of the federal budget. According to the latest figures from the CBO, Medicare and Medicaid will spend nearly \$1.2 trillion dollars in 2019.³ That is more than 25 percent of the federal budget and Medicare and Medicaid's share grows every year. Medicare and Medicaid's share of the federal budget will rise to 32 percent in 2029. More concerning is the long-term structural deficits of these programs. It is estimated that over the next 75 years, Medicare faces a shortfall approaching nearly \$40 trillion, an incomprehensible figure even in Washington.⁴

² <https://www.wsj.com/articles/SB10001424127887323971204578626151017241898> & <https://www.modernhealthcare.com/article/20190124/NEWS/190129962/mc-enrollees-last-in-line-when-docs-accepting-new-patients>

³ May 2019 10-Year Budget Projections

⁴ <https://www.dailysignal.com/2019/02/20/medicares-financial-condition-is-getting-worse-heres-what-trump-and-congress-can-do/>

The intersection of virtually limitless demand and constrained supply is a shortage. Shortages come in many forms in healthcare and can be found virtually anywhere that a government has manipulated the system to shield patients from prices.

In the United States, as noted above, we are beginning to see shortages in terms of the number of doctors actually willing to accept Medicare and Medicaid. We also see shortages in the form of poor quality of care and long wait times in systems like the Veterans Affairs (VA) medical system. Many veterans were simply left to die on waiting lists while VA officials fabricated data on wait times, as we sadly learned just a few short years ago.⁵

Socialized medical systems overseas, such as the National Health Service (NHS) in the United Kingdom, almost always rely on price controls and are plagued with shortages. The NHS is not just dealing with excessive wait times, a well-known problem with the system, but now scheduled surgeries are being canceled and common procedures such as cataract removals, hip and knee replacements, glucose monitors for diabetes patients, and hernia surgeries are being discontinued in some areas.⁶

Sally Pipes, President of the Pacific Research Institute, explains what's at the core of the NHS's problems:

"Patients face long wait times and rationing of care in part because the NHS can't attract nearly enough medical professionals to meet demand. At the end of 2018, more than 39,000 nursing spots were unfilled. That's a vacancy rate of more than 10%. Among medical staff, nearly 9,000 posts were unoccupied."

"These shortages could explode in the years to come. In 2018, the Royal College of General Practitioners found that more than 750 practices could close within the next five years, largely because heavy workloads are pushing older doctors to retire early."⁷

An April 2018 report to the House of Commons of the United Kingdom lays bare the funding problems that face the NHS:

"NHS England assessed the likely cost of future health needs and compared this to the future funds available to purchase that care. Its analysis used seven years of flat 'real' spending on health. This modelling process indicated that the NHS would face a funding gap of around £30 billion between 2013/14 and 2020/21."

"The NHS Five Year Forward View (FYFV) proposed major changes to the provision of healthcare services. It identified that the NHS will need to continue to adapt in response to increasing patient demand, funding constraints and new technologies and treatments."⁸

To summarize, heavy workloads are pushing healthcare workers to retire early and they aren't being replaced. Demand subsidized by hiding the price of healthcare

⁵ <https://www.cagw.org/thewastewatcher/va-scandal-refuses-end>

⁶ <https://www.forbes.com/sites/sallypipes/2019/04/01/britains-version-of-medicare-for-all-is-collapsing/#1e51ca6836b8>

⁷ Ibid.

⁸ <https://researchbriefings.files.parliament.uk/documents/SN00724/SN00724.pdf>

from patients has overwhelmed the system and budget constraints mean healthcare providers are not compensated enough to enter the market. Patients save nothing because they are promised free healthcare, but increasingly end up getting what they pay for, which is poor service and long waiting lines.

The problem of healthcare shortages are pervasive across Europe, and indeed much of the rest of the industrialized world, where the heavy hand of government regulates prices by either nationalizing the system such as in the United Kingdom or imposing outright price controls on the private sector. Nowhere is the effect of this more apparent than in the pharmaceuticals market, where most European nations regulate prices directly or through their government healthcare monopolies.⁹

Drug Price Controls May Be Worst of All

Just as doctors in the United States are increasingly less-willing to see Medicare and Medicaid patients and doctors in the United Kingdom are less willing to work for the NHS, the economics of price controls make pharmaceutical companies less-willing to provide drugs to the market and invest in drug research and development. The evidence of this is stark.

When compared to the United States, where drug companies are largely free to recoup their costs, the rest of the world seriously lags behind in research and development:

“In 2015, spending on drug research and development in the United States totaled an estimated \$47.1 billion versus \$37.3 billion in Europe. From 2002 through 2016, the average growth rate in pharmaceutical research and development spending in the United States was 5.43 percent compared to 4.23 percent in Europe. American pharmaceutical companies have also consistently led the world in discovery of new chemical and biological entities with 304 between 1997 and 2016, compared to 252 for European companies, 102 for Japanese firms, and 68 for the rest of the world combined.”¹⁰

The rest of the world also lags dramatically behind in terms of drug access, another form of a healthcare shortage:

“The United States accounted for 64.7 percent of sales of all new medicines introduced between 2011 and 2016, compared to 17.5 percent combined in Italy, France, the United Kingdom, Spain, and Germany, and 7.3 percent in Japan... 95 percent of new cancer treatment drugs launched globally are available in the United States, whereas only 74 percent are available in the United Kingdom, 49 percent in Japan, and Just 8 percent in Greece.”¹¹

With such staggeringly low levels of access, the cost of “free” or price-controlled drugs may be your life.

⁹ http://ctwinvestmentgroup.com/walgreen/wp-content/uploads/2014/12/GOe_FP_Pharmaceutical_Pricing_Europe_CtWInv_final_forPublication.pdf

¹⁰ <http://fw-d7-freedomworks-org.s3.amazonaws.com/POISON%20PILL.pdf>

¹¹ Ibid.

The idea that international reference pricing has discovered some holy grail that is immune from the laws of supply and demand is thus categorically false. Price controls are not a new concept in medicine. Imposing price controls on pharmaceuticals is just a repackaging of the same ideas of government price-shielding that plague our current system and cause all of its less-than-desirable features. While something must be done to address spiraling healthcare costs combined with the threats to patient access, doing more of the same, subsidizing demand and constraining supply, will only produce more of the same.

Whatever we choose to do to make drugs less expensive, we must not put at risk the innovation that makes wonder drugs available in the first place. Price controls sound wonderful, but studies show that they often inhibit drug development. So there is a trade-off.

There is a right way and a wrong way to make drugs and vaccines more affordable. The wrong way is for government to artificially hold down prices through price controls or reimportation of drugs (which is just a way to reimport price controls from other nations).

The right way to lower drug costs is to stop allowing foreign countries to evade our patent laws and impose their own price controls. Many of our major trading partners — including rich countries such as Canada and the European Union members — have long enjoyed the fruits of American-funded progress on the cheap, thanks to state-sponsored price controls. They have been doing so for years.

This “free rider” problem raises drug prices here at home because when foreigners pay below-market prices for the drugs, they escape the cost of underwriting the critical research and development investments. The cost of developing a new life-saving drug can be as much as \$2.5 billion. American consumers are the suckers who have to pick up the tab.

It is grossly unfair that Canadians and Germans pay less than Americans do for drugs that were developed in the United States. The average American spends \$876 per year on prescription drugs, compared with \$503 for people living in the European Union. No surprise, our investment in pharmaceutical research and development (R&D) is also much higher: \$233 per capita, compared with just \$73 in Europe.

Foreign price controls also slow scientific progress and the race for cures. A study from the U.S. Department of Commerce found that price controls in just a small number of Organization for Economic Co-operation and Development (OECD) countries had reduced funding by between \$5 billion and \$8 billion per year, preventing the development of three to four new drugs annually.

Another study using data from the National Institutes of Health and the Centers

for Medicare and Medicaid Services calculated that if OECD countries lifted all price controls on prescription drugs, the resulting increase in pharmaceutical R&D investment would yield eight to 13 new drugs per year through 2030. What if one of these delayed drugs is a cure for multiple sclerosis or Parkinson's or Alzheimer's?

President Trump has correctly pledged to fight to reverse these violations of American intellectual property in upcoming trade negotiations. He denounced "foreign freeloaders" and has directed his trade representative to "make fixing this injustice a top priority" in negotiations with every trading partner.

Europe and Canada are perfectly content to allow Americans to subsidize innovation while they reap the benefits at knockdown prices. Then they boast about how they pay less for health care than we do. Yes, it's easy to cut your expenses when someone else is picking up the tab. But American consumers won't stand for this gambit anymore.

Patents Not Price Controls

No nation has come close to the United States in finding new cures for painful and deadly diseases. The U.S. accounts for over half of all new drugs developed, according to the Milken Institute. This isn't just because we have the most brilliant and innovative medical researchers or that we have the world's best labs – which we do – it's also because we provide a financial incentive for drug development. We spend \$70 billion a year on drug development, far more than any other nation.

What is needed is better safeguards to protect our patents. In the new Canada and Mexico trade deal, President Trump just negotiated a deal that protects intellectual property (IP) and data protections for U.S. innovators. These standards should be the foundation for even stronger trade deals with Europe and Asia going forward. If other nations pay their fair share, it will lower prices for Americans as new and incumbent drugs compete. One dramatic example of this process is the tumbling cost of hepatitis C drugs, which fell by 60 percent to 80 percent within just a few years due to the introduction of "follow-on" rivals.

Other steps can be taken as well to create an innovation-rich environment for new drug development that spreads the cost to all the citizens of the world who will benefit. While foreign governments employ all kinds of regulatory ruses and bureaucratic smokescreens to artificially depress drug prices, rolling back a handful of the worst distortions would go a long way towards restoring transparency and reciprocity to the global pharmaceutical marketplace.

These include:

1. Compulsory licensing as usually practiced refers to national governments stripping drug makers of patent protections for new drugs on trumped-up grounds of a

“national emergency,” without the need to first seek a voluntary compromise with patent holders, allowing their domestic drug makers to produce generic versions when no real emergency exists. India for example has used compulsory licensing to build its lucrative generic drug industry, which sells the generic versions for a substantial profit as well as for export, giving the lie to the alleged emergency and cost concerns.

2. International reference pricing is another deceptive strategy in which rich countries peg prices to an average or even lowest price drawn from a “sample” of other countries, typically excluding “outliers” on the high end (that is, their peers in the developed world) while stacking the figures with low-income countries and countries that have already adopted onerous price controls. In addition to deterring innovation, this has been found to delay the introduction of new drugs in countries that implement it by over a year.

3. Health technology assessment (HTA) describes various systems for evaluating the clinical and cost-effectiveness of new drugs, which informs the price set by the government as well as health rationing decisions. However, HTA is rendered incoherent by the absence of a rigorous methodology, based on empirical findings and consistently applied, leading the U.S. to disband its Office of Technology Assessment in 1995. This incoherence allows assessors to formulate their own, arbitrary measures for cost-effectiveness. According to research commissioned by the European Union, HTA as currently practiced “contributes to impeded and distorted market access, leading to... negative effects on innovation.”

4. Therapeutic reference pricing compares the effectiveness of new and existing drugs for the same conditions, grouping them in broad “therapeutic reference classes” to justify price controls on new treatments on the grounds that they are interchangeable with older ones. This unsophisticated approach typically fails to recognize incremental advances, as well as variations in efficacy and tolerability among patients and the fact that a single drug can be indicated for different conditions, and further distorts pricing decisions by mixing generic and patented drugs in the comparison set.

5. Counterfeiting drugs and vaccines blatantly violates American IP. This is a big problem in nations like China, where IP protections are virtually unenforced. IP is a central pillar of American (and global) prosperity in the 21st century. It is the lifeblood of the modern information economy, and a growing percentage of the value-added that America brings to the global marketplace. Like so many of America’s other IP-intensive products—such as computer software, copyrights, robotics, artificial intelligence, music, and movies—our pharmaceutical products require stringent IP protections to be clearly and unapologetically laid out in our trade agreements and vigorously enforced by the Trump administration. By fostering competition and increasing the number of new entrants to the international drug marketplace, a more

equitable system for sharing the costs of pharmaceutical innovation will lead to lower drug prices both in the U.S. and abroad, not to mention increased longevity, a higher standard of living, and economic gains measured in the trillions. American innovation is shared openly with the world. Its costs should be too.

Enforcement of our intellectual property and our patent rights is not just good economics. It will assure that the brightest minds of the world win the race for the cure and eradicate some of the most deadly diseases that still afflict us. In other words, in the medical industry, free enterprise is good for your wallet and good for your health.



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