



Research Report

July 6, 2000

Economics 101: Why Pharmaceutical Price Controls Won't Work

"Limitations on the prices of commodities are not only ineffectual for the purposes proposed, but likewise productive of very evil consequences to the great detriment of the public service and grievous oppression of individuals."

-The First Continental Congress, June 1778

The benefits provided to consumers by the pharmaceutical industry over the past few decades are immeasurable. No one questions the role of antibiotics in eliminating diseases or the use of chemotherapy drugs in treating cancer. Many believe the prominence of drugs in the health care arena serves a preventative role; patients on prescription medication are less likely to seek repeated treatment by a doctor, and they are less likely to need expensive hospitalization and acute medical care.¹ A recent study found that every dollar spent on prescription drugs is associated with a \$4 decline in hospital spending.² Policy makers, concerned with skyrocketing health care costs, believe pharmaceuticals will save considerable money for government health care programs. They believe that contemporary medications could keep their patients healthy longer and, thereby, cut costs. One study concluded, "Open access to pharmaceuticals provides the best assurance of quality health care on the most cost-effective basis."³ The benefit of prescription drugs to the consumer is so high that some government officials now seem to believe that affordable access to these drugs should be considered a right.⁴

The Economics of Pharmaceuticals

Unfortunately, the obvious benefits that accrue from prescription medications are sometimes offset by one significant problem — cost. Pharmaceutical drugs, especially the newest and most beneficial ones, are expensive to develop. The pharmaceutical industry spends more on research and

development (R&D) than any other industry in America (\$24 billion in 1999), and 40 percent of that money is spent on researching drugs that never make it to the market.⁵ According to recent figures, the cost of developing one drug (from the initial idea to the first bottle in Walgreen's) amounts to around \$500 million.⁶ In order to recoup the R&D cost of a new drug, a company must charge prices to cover the costs of R&D on that product, the products that are researched, but not developed, and the basic cost of manufacturing the product.

The cost of a generic drug is based solely on the cost of manufacturing, because generic drug manufacturers do not participate in R&D. Such generic products are not available until the original patent expires (usually several years), ruling out their use as discounted alternatives to new innovative drugs.

Recently, it has become politically popular to express concerns about the affordability of the newest drugs that doctors may prescribe. At the federal level, this debate focuses on senior citizens' ability to pay for prescription drugs. However, recent studies have found that two-thirds of seniors have access to affordable prescription drugs.⁷ In addition, the Pharmaceutical Research and Manufacturers of America (PhRMA) maintains a "Patient Assistance Program" that collaborates with pharmaceutical companies to provide free drugs to the uninsured and those otherwise unable to pay for prescriptions. Despite sensationalism of the issue by the media, those with the greatest need for pharmaceutical drugs have many options available to them.

A Case For Price Controls?

Some critics point to the fact that, in countries which employ pharmaceutical price controls, the price of prescription drugs is significantly lower than in the U.S. However, the Organization for Economic Cooperation found that in comparison to other countries with price controls, Americans spend less per capita per year on prescription drugs than Germany or France, and only slightly more than Canada and Italy.⁸ A Wharton School of Business study found that the conclusions of such studies on price comparisons vary, depending on the sample of drugs chosen, the inclusion of generics in the study (which make up 45 percent of U.S. prescriptions), and the weighting of prices.⁹ Price controls have unintended consequences as well. In Canada, price controls on prescription medications are

common and shortages of drugs and other medical procedures are so frequent that some Canadians cross the border into the U.S. for treatment.¹⁰

It is important to note, however, that lower drug prices in countries like Canada are not only attributable to price controls. To some extent, the lower prices are the result of tort reforms within the health care system that protect companies from exorbitant jury awards. Pharmaceutical companies in Canada incur lower legal costs, which in turn have led to lower prices for the consumer.

The Problem With Price Controls

Despite the ambiguous and inconclusive claims in favor of pharmaceutical price controls, states like Texas, California, New York, and Virginia are presently considering such programs as a solution to rising drug prices. The House Committee on Public Health recently heard testimony on price controls from a State Senator in Maine who helped pass legislation to impose price controls on pharmaceutical drugs in that state. During the 76th Legislative interim, the Public Health committee is charged with investigating pharmaceutical cost-drivers within Texas and identifying any opportunities to reduce costs. Because some legislators appear to favor pharmaceutical price controls in Texas, it is important to point out that such an approach may create more problems than it would solve.

A price control is a government-imposed mandate to lower the price of a product below the current market price. Price controls are, by definition, attempts to replace the free market system with government control. In basic economics, the supply of a good in the market (S) is driven by the demand for that good by consumers (D) (fig. 1). Supply and demand vary in terms of price and quantity. Consumers want more quantities of a good when it is cheaper and less of that good when it is more expensive. Suppliers, on the other hand, produce more of a good at a higher price than they would at a lower one. The point

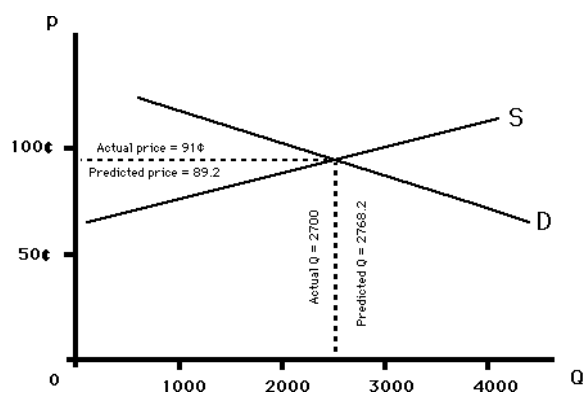


Fig. 1. The basic supply and demand curve under pure market conditions.

where the supply line meets the demand line is the equilibrium, where the price and quantity of a good in the free market are determined.

Under a price control, the price of a product is artificially set below the equilibrium price (fig. 2). By analyzing the chart, the demand for the good (the

quantity where the price line meets the demand line) is now much higher than it was at the original equilibrium, since consumers would buy more of a good if it were cheaper. However, the supply of the good under price controls (the quantity where the price line meets the supply line)

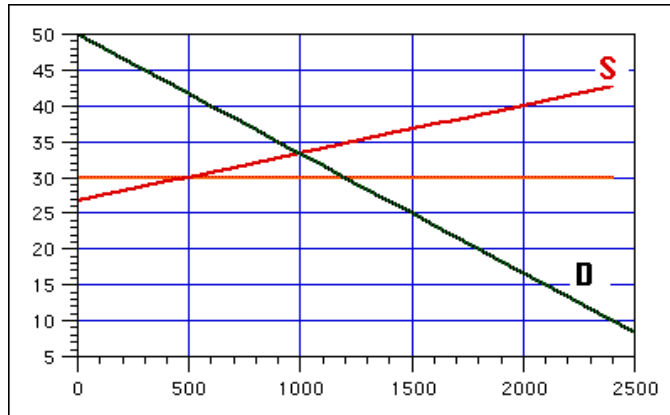


Fig. 2. Chart represents a price control in the market (price cap is the horizontal line).

has been reduced, since the producer would not want to sell a good below the market-driven price. So, with demand increased and supply decreased, the overall effect of a price control is a shortage of the product.

Basic economics teaches that price controls cause shortages. Even the hint of price controls can sometimes create the threat of a shortage. For example, spending on R&D by pharmaceuticals has grown at a rate of 10 to 22 percent every year since 1980, except during the 1994 debate over the Clinton health plan proposal, when spending increased only 6 percent.¹¹ Manufacturers feared that if the proposal to enact price controls were to pass, their costs for developing new drugs would soon become higher than the meager profits that would be realized under price controls. Once the Clinton plan was defeated, R&D growth resumed to its normal level. Other statistics show that pharmaceutical R&D in America represents 36 percent of worldwide R&D spending. U.S. companies have developed 45 percent of drugs created from 1975-1994, far outpacing those countries with price controls.¹²

Also, with government in charge, the shortage caused by price controls could result in the rationing of drugs to only the patients it designates. Many consumers who might need a drug and who might be able to pay for it would not

be allowed to purchase that drug. In 1994, the government set price controls for Medicare patients for a drug used to treat kidney failure. Faced with increased demand, the government then rationed the drug by establishing a set of criteria for the severity of the illness to be met in order to receive the drug. Medicare patients in need of treatment with the drug, but who didn't meet the criteria for eligibility, were denied the product.¹³

The price controls implemented in Maine require that pharmaceuticals sold in the state be sold at a price equal to the lowest known price for the drug, whether that be in Canada or the Veteran's Administration. Confronted with such a scenario, pharmaceutical companies really have only two choices: 1) increase prices for all groups receiving discounts in order to recover the cost of R&D, or 2) go out of business. This effect, on a small scale, occurred in the aftermath of the Omnibus Budget Reconciliation Act (OBRA) of 1990. That act mandated that Medicaid programs be given a discount of at least 15 percent off the manufacturer's price of a drug. Meanwhile, HMO's and other managed care groups saw their negotiated discounts on drugs fall from 26 percent to 15 percent as pharmaceutical companies reclaimed the revenue lost to Medicaid by hiking up prices for other consumers.¹⁴

When the Congressional Budget Office (CBO) later evaluated the impact of OBRA, it found that "Price controls on one type of service create incentive for providers to substitute other services for the controlled one."¹⁵ Price controls, then, would *discourage* the use of drugs and encourage the use of less effective and more expensive health services, even in light of the aforementioned cost savings that result from using pharmaceuticals (\$4 saved for \$1 spent). The CBO further stated, "Price controls established for a specific population group (such as Medicaid enrollees) may result in higher prices charged to other population groups."¹⁶ The CBO concluded its evaluation of price controls by saying that without intensive regulation and "systematic" monitoring of relevant industries, "[price controls]' potential to solve the problem of health care costs is limited."¹⁷ If price controls are implemented nationwide (or even slowly state-by-state), drug companies inevitably would have to raise the price charged to all consumers until the "discounted" price for government programs like Medicaid and private programs for the elderly or uninsured would rise to equal that charged to those in the private sector.

The quality of prescription medications could also be at risk under price controls. In a conclusion corroborated by several researchers, pharmaceutical industry representatives claim that when confronted with lower prices for their products, drug-makers would be forced to reduce production costs and even curtail the development of new drugs.¹⁸ Such cost-cutting measures would lead to fewer and poorer choices for consumers. And in a related scenario, price controls could easily produce a black market for popular medications, with unregulated and even counterfeit medications flooding the market. For example, in Mexico, with its low prices and high demand, it is estimated that one-fourth of the drugs sold are counterfeit.¹⁹

Solutions

A principled approach to government would focus attention first on solutions that would neither expand government nor inhibit the free market. To that end, much work is being done by the private sector to develop potential remedies to compensate for the high cost of prescription drugs. For instance, *PhRMA* and the Heritage Foundation have done significant research to find solutions that would not destroy free market efforts to provide innovative and life saving drugs for all consumers who need them.²⁰ It is important to remember that the number of Medicare recipients who are unable to pay for prescription medication is approximately 35 percent, meaning that the remaining 65 percent already have a prescription drug plan that allows them to buy drugs at affordable prices.²¹ Among the options being proposed to assist the 35 percent who are at risk are: 1) create new insurance policies tailored to the needs and the means of this group, 2) step up efforts to implement tort reforms that would limit excessive judgments and eliminate unnecessary litigation and, 3) should private sector solutions fall short, explore reasonable measures to provide prescription drug benefits through Medicare to those who are most in need.

In developing public policy, lawmakers must always be aware of the law of unintended consequences which states that changes intended to correct one problem sometimes inadvertently cause problems in other areas. Clearly, implementing price controls on pharmaceuticals would be an example of this law in action; therefore, it would be the wrong way to respond to the need for increased access to affordable prescription drugs. Such an approach would ignore viable and

potentially more economical private-sector solutions to the problem, and it could also permanently damage the pharmaceutical industry. The resulting shortages of prescription drugs, combined with the potential of lesser quality drugs coming to the market, could negatively impact the health of all Americans.

Price controls have always been a failure economically, politically, and socially. Countries that have implemented such policies are dealing with shortages of prescription drugs, long waits to receive the newest medications, poor quality drugs, and counterfeit drugs. Texas needs to avoid the pitfalls other states and countries have faced and implement policies that demonstrate what can be accomplished when the individual and the free market combine to create innovative products at competitive prices to improve the length and quality of life.

¹ Strongin, Robin, National Health Policy Forum. Testimony before the Texas House Committee on Public Health, 23 May 2000.

² Goldberg, Robert. "Ten Myths about the Market for Prescription Drugs," National Center for Policy Analysis Policy Report No. 230, October 1999.

³ Pharmaceutical Research and Manufacturers Association, "Texas: A Medicaid Model," February 16, 1999, <www.phrma.org/facts/bkgrndr/texas.html>.

⁴ Pingree, Chellie, Maine State Senate Majority Leader. Testimony before the Texas House Committee on Public Health, 23 May 2000.

⁵ Orzechowski, William, Ph.D. and Walker, Robert C., "Dose of Reality: How Drug Price Controls Would Hurt Americans," Policy Paper No. 125, (Arlington, VA: Orzechowski & Walker Consulting, 7 February 2000), p. 1, 3.

⁶ Pharmaceutical Research and Manufacturers of America, "Why Canadian Price Controls on Medicines and Rationing of Health Care Should Not be Imported into the U.S.," December 1999, <www.phrma.org/facts/bkgrndr/import.html>.

⁷ Goldberg, Robert. "Ten Myths about the Market for Prescription Drugs."

⁸ Goldberg, Robert. "Ten Myths about the Market for Prescription Drugs."

⁹ Orzechowski, William, Ph.D. and Walker, Robert C. "Dose of Reality," p. 1,5.

¹⁰ Pharmaceutical Research and Manufacturers of America, "Why Canadian Price Controls..." p. 1

¹¹ Orzechowski, William, Ph.D. and Walker, Robert C. "Dose of Reality," p. 5.

¹² Orzechowski, William, Ph.D. and Walker, Robert C. "Dose of Reality," p. 1,4.

¹³ Goldberg, Robert. "Ten Myths about the Market for Prescription Drugs."

¹⁴ Orzechowski, William, Ph.D. and Walker, Robert C. "Dose of Reality," p. 8.

¹⁵ The Congressional Budget Office, "Rising Health Care Costs: Causes, Implications, and Strategies," (Washington DC: April 1991), cited from "Ragnar's Corner, Essays on Libertarianism," (Houston, TX: 15 October 1994), <www.appsmiths.com/~ervan/ragnar/Mesg162.html>.

¹⁶ The Congressional Budget Office, "Rising Health Care Costs."

¹⁷ The Congressional Budget Office, "Rising Health Care Costs."

¹⁸ The Independent Institute, "Drug Price Controls: A 'Cure' Worse Than the Disease,"

<www.independent.org/tii/Research/GuideHealthCareIssues.html>, accessed 19 April 2000.

¹⁹ Kowalski, Tom, Texas Health and Bioscience Institute. Testimony before the Texas House Committee on Public Health, 23 May 2000.

²⁰ The Independent Institute, "Drug Price Controls: A 'Cure' Worse Than the Disease,"

<www.independent.org/tii/Research/GuideHealthCareIssues.html>, accessed 19 April 2000.

Froge, James, "How to Provide Prescription Drug Coverage Under Medicare," (Washington DC: The Heritage Foundation, 16 June 1999).

²¹ Goldberg, Robert. "Ten Myths about the Market for Prescription Drugs."