FORUM

The Healthcare FORUM

An ongoing discussion of healthcare problems, goals, innovations, and solutions.

Thanks in large part to a generous grant from Kaiser Permanente, *Oregon's Future* will continue to explore healthcare over the next three years.

Visit the *Oregon's Future* website **www.oregonfuture.org** to review past installments of healthcare on such topics as end of life issues, information technology, universal healthcare, and public health.

Fall 2002

Public Health & Healthcare

Spring 2004

Public Health vs. Healthcare

What is Oregon's Best Investment?

Fall 2005

Economics of Health

Layperson to Layperson

Are Drugs Responsible for the High Cost of Healthcare?

by Jay Hutchins, Executive Editor

When *Oregon's Future* began covering healthcare, many of our advisors warned us that most people misunderstand the pharmaceutical pricing issue and its impact on healthcare costs. Large drug companies have, indeed, been fined hundreds of millions of dollars for bilking taxpayers and consumers in schemes to overcharge Medicare and Medicaid, and for aggressive marketing to physicians of unproven, off-label uses for drugs. In spite of these and other transgressions, our advisors and many well-known economists support the idea that drug companies and drug prices are not the major problem with healthcare in the US.

Uwe Reinhardt

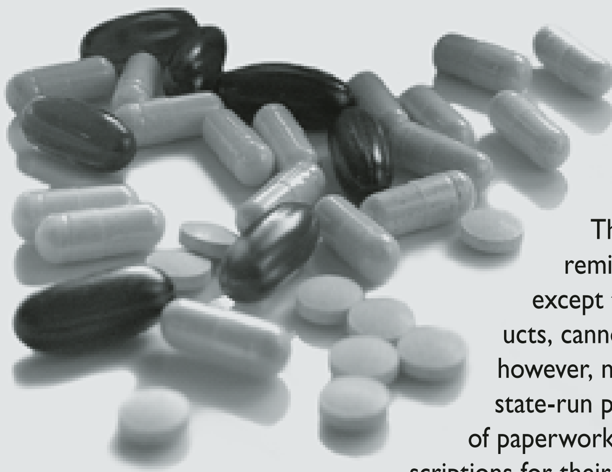
Uwe Reinhardt, PhD, a well-known Professor of Economics and Public Affairs at Princeton University, often advocates universal healthcare. His work on costs and affordability is referenced by health economists all over the world. In a presentation for the Kaiser Foundation's *Healthcasts*, he points out that total drug spending is only about 1 percent of gross domestic product (GDP) and drug companies' profits are less than one quarter of this 1 percent. The total cost of healthcare currently produces 15 percent of our GDP—almost a sixth of our economy.

Our advisors and many well-known economists support the idea that drug companies are not the major problem with healthcare in the US.

Reinhardt explains that the major problem with the cost of drugs is that drug companies continually seek to replace existing drugs with ones that are just a little better—but a lot more expensive. Unless more costly medication can be proven to provide definitive health advantages, he rec ommends that consumers foot the bill for new patented drugs—not government or insurers. He puts the onus on Congress for devising a way to share more effective drugs with the chronically ill, those with low-incomes, and the elderly without drug coverage.

Danzon and Furukawa

In the 2003 *Health Affairs* article, *Prices and Availability of Pharmaceuticals: Evidence from Nine Countries*, health economists Patricia M. Danzon and Michael F. Furukawa suggest that peoples' perception that drug prices in the US are too high is partly attributed to the difficulty of making price comparisons between countries. This is mainly because each country's pharmaceutical market is different. Strict standardization between countries for presentation, strength, pack size, and manufacturers of drugs does not exist. Danzon and Furukawa address this problem by simplifying matching requirements to make useful comparisons.



Drug Reimportation: *Is it worth it?*

The US government has consistently reminded the states that companies, except those importing their own products, cannot import non-FDA-approved drugs; however, no legal action has been taken against state-run programs. Individuals—through lots of paperwork—can import 90 days worth of prescriptions for their own use. The FDA has been holding hearings, and Congress has produced several bills as part of the most recent efforts to address current restrictions on imports. At issue is whether or not to allow companies to reimport drugs that were previously exported from the US. The previous two efforts—The Prescription Drug Import Provisions of the FY2001 Agriculture Appropriations Act, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 didn't solve the problem of broadening access to drugs. All other bills are still in subcommittee and are considered unlikely to be approved during this Congressional session.

At publication of this issue of *Oregon's Future*, at least 12 states have authorized websites that help their residents buy cheaper prescription drugs from Canada. Illinois, Wisconsin, Missouri, Kansas, and Vermont have implemented their own import programs (called I-SaveRx) through CanadaRx Services, Inc. but public response has been slow; through May, the Illinois drug-import program had processed only 6,300 orders since it started in October. Two other state-run Internet programs that connect customers directly with foreign pharmacies have filled around 13,000 prescriptions since early 2004. In comparison, 22 million free prescriptions were filled in 2004 through programs operated by US drug companies. California healthcare advocates have decided that Canada cannot do much to lower their drug costs and Canadian imports will not be part of any solution to the problem of high drug prices there.

When purchasing prescription drugs, consumers should make comparisons of actual costs for the same product and should be aware that Canadian drugs are not always the most affordable choice. Generic drugs are generally less expensive in the United States than they are in Canada and there are some generic drugs approved in the United States which are not available in Canada.

Generic drugs are generally less expensive in the United States than they are in Canada.

Many economists believe that an open, international market for drugs would have positive long-term economic effects on world trade. They also point out that such a market would also increase prices for many underdeveloped countries. Economists of varying ideologies predict that if the US legalizes commercial importation of US-made pharmaceuticals from other countries such as Canada, drug prices will rise abroad more than they will drop in the US.

The Congressional Budget Office has concluded that re-importation of US-made drugs would, in the long term, reduce prescription drug spending by only about 1 percent.

Marie Godfrey, PhD

The cost of patented drugs in the US is 25 to 40 percent higher than in places like England, France, and Canada. What makes Danzon and Furukawa's study interesting and enlightening is that they apply a concept known as purchasing power parity to compare patented-drug prices to the cost of other goods and services within Canada, Chile, France, Germany, Italy, Japan, Mexico, and the United Kingdom to those in the US.

When they compare the cost of drugs manufactured in the US to purchasing power in each country, the price of patented drugs in the US drops from 33 to only 14 percent higher than the same drugs sold in Canada. When compared to Germany and the United Kingdom, drug prices in the US are actually cheaper. Italy and Japan are nearly equal to the US. In Mexico and Chile, drugs are much more expensive than the in the US.

Furukawa and Danzon speculate that the tendency for people to compare US drug prices to Mexico's, combined with the possibility of re-importation, may discourage pharmaceutical companies from pricing drugs more in line with Mexico's average per capita income.

Their data indicate that regulated countries, which use price controls and restrictions on marketing (the US had some restrictions on marketing until 1997), tend to have lower prices for patented drugs than the US. They also conclude because of fierce competition between manufacturers, generics sold within our borders are as cheap as, or cheaper than generics sold in other developed countries even before purchasing power parity is calculated. Finally, they point out that when prescription medicines in the US become over-the-counter drugs, they become the cheapest in the world.

High Prices

Malcolm Gladwell, the well-known author of *The Tipping Point and Blink*, is the author of *High*

Prices: How to think about prescription drugs in the October 25, 2004 edition of the *New Yorker*.

In *High Prices*, rather than arguing that the United States has the most expensive drugs in the world, he makes a case for saying that we have a different pricing system than other countries. He gives an eye-opening example that supports Danzon and Furukawa's conclusion about generic drugs:

> A 20-mg pill of Mevacor, for high cholesterol, is $2.25 in America and less than $2.00 in Canada. The generic version of Mevacor, called lovastatin, is approximately $1.00 for a pill of the same dosage in Canada but can be purchased for as low as 65 cents in the US.

Obviously, not every drug has a generic equivalent and this places a burden on those who cannot afford the higher prices of patented drugs.

However, as Jesse Eisenger reports in the October 13, 2004 edition of the *Wall Street Journal*, a large number of highly profitable drug patents have expired and many more will expire in the next few years. This includes drugs such as Lipitor, the highly effective and expensive cholesterol-lowering medicine whose patent expires in 2011.

There are also many patented drugs that, while slightly better than a placebo, are essentially no more effective than an old-time remedy. The National Institute of Health (NIH) even hired 600 doctors to counter 90,000 drug representatives and spread the word that old-fashioned, inexpensive diuretics are often as effective as high-end patented hypertension drugs.

They point out, among other things, the seldom-discussed fact that 75 percent of healthcare costs are attributed to labor.

This NIH initiative raises an interesting idea: The prescribing of major drugs in our employer-based insurance system is now being treated as a public health issue—mainly because too few patients and doctors have appropriate information or incentives to learn what is cheapest as well as effective. The issue of incentives and information appears to be much more important than the retail cost of drugs.

Whatcom County

In her article, *Whatcom County Experience* in this edition of the *Oregon's Future* Healthcare Forum, **Mary Minniti** highlights the idea that if our healthcare system had better incentives for providers and patients to use care, medical knowledge, and technology more efficiently, then drug companies would be big winners—but the overall cost of care and expensive procedures would go down. **Minniti** is the program director for The Pursuit of Perfection project in Whatcom County, Washington. Data from the program's first two years indicate that improvement in the management of chronic conditions in Whatcom County would immediately shift the flow of cash from providers to pharmaceutical companies and Medicare—and in the long term, to the insurance companies. In other words, hospitals and clinics would be the financial losers. Well-known medical economist J.D. Kleinke, who was formerly based in Portland, has pointed out for years that improving chronic care will include a greater use of drugs rather than less.

A Dollar a Day Keeps the Hospital Away

In his presentation on the *HealthCasts* website, Uwe Reinhardt references National Ambulatory Survey data that indicates a $1.00 increase in pharmaceutical expenditures results in $3.65 in reduced hospital expenditures. Even though he is referring to 1990 data, which may be conservative, the meaning is clear. This shifting of cash away from hospitals and clinics toward drug companies seems to be a problem that needs to be solved in order for providers to afford serious healthcare reform.

Depending upon whether one speaks to the lobbying arm of the largest pharmaceutical companies—PhRMA—or AARP, patented drug costs have been rising between 4 and 7 percent a year. Both values are below the inflation rate of healthcare in general, which in 2004 was 8.2 percent. The total cost of drugs is less than 10 percent of medical costs (only 1% of GDP), so even if someone convinces us that all drug companies in the US are run by crooks, the cost of prescription drugs still is not the prime candidate for the major problem with healthcare.

Sharma and Gehring

In our current installment of the Healthcare Forum, **Rajiv Sharma** and **Renu Gehring** discuss in their article, *Incentives: Quality and Prices*, the lesser known reasons that healthcare is so expensive, and suggest a way to create politically viable incentives in payment systems to improve quality. They point out, among other things, the seldom-discussed fact that 75 percent of healthcare costs are attributed to labor.

Of Interest

For fun and edification, I suggest reading *Spin Doctored: How drug companies keep tabs on physicians* by Shannon Brownlee and Jeanne Lenzer. The article discusses how the American Medical Association and the government sell coded lists of physicians' Drug Enforcement Agency (DEA) ID numbers to pharmaceutical companies, who in turn match them with lists of prescriber profiles sold to them by pharmacies. These are used to target the prescribing behaviors of each of the approximately 600,000 physicians practicing medicine in the US. Shannon Brownlee writes well and often about healthcare. Many of her articles can be found at the very liberal New America Foundation website.

Other Issues

Marie Godfrey updates us on the state of drug re-importation programs and the bills in Congress meant to address this issue. She also pulled together information on discounted prescription programs, which is not only helpful to the public but also gives some perspective on the drug companies' interest in providing expensive drugs to low-income individuals and families.

Jim Dameron, Director of the Oregon Patient Safety Commission, discusses how the Commission will address the advantages gained from better reporting of medical errors in Oregon. Numerous authors in past editions of *Oregon's Future* have pointed out that many countries with universal healthcare systems are experiencing rising costs for services and similar problems with medical errors as the US. The attention paid by Congress and State governments to the cost of drugs is important. However, unless other issues are understood by the public and addressed by government and the private sector, overall costs will continue to rise and the quality of care will continue to be unreliable.

Articles discussing these issues and other important healthcare topics can be found in previous editions of *Oregon's Future* at www.oregonsfuture.org.

Furukawa and Danzon's study was supported by a grant from Merck and Company. A white paper produced by the FDA corroborates information discussed in Danzon and Furukawa's article at http://www.fda.gov/oc/whitepapers/drugprices.html. The Wall Street Journal piece that discusses the NIH's hiring of physicians to counter the drug reps' influence on their colleagues is from the February 17, 2004 edition. Malcolm Gladwell's article can be accessed at http://www.gladwell.com and is well worth the time.

Discount and Free Drug Programs

These free programs match low-income people with public and private assistance and help them obtain free or discounted medicine. Drug assistance programs industry-wide filled 22.1 million prescriptions with a wholesale value of $4.18 billion last year, according to the Pharmaceutical Research and Manufacturers of America (PhRMA).

As the issue of prescription drug prices continues to capture the media's attention, the number of new programs promising to "cut your prescription costs" will certainly explode. As with many issues, awareness, caution, and information are essential even for government-sponsored programs. Most programs require you to supply personal details you may wish not to share over the Web. Do not pay for access to these programs without knowing what you're getting into.

PARTNERSHIP FOR PRESCRIPTION ASSISTANCE
http://www.pparxor.org
or call 1-888-477-2669 This program will check your eligibility for assistance from individual pharmaceutical companies. The Partnership then matches each applicant, on a case-by-case basis, with programs that they are eligible for.

THE MEDICATION FOUNDATION
http://www.medicationfoundation.org
Lane County residents only
http://www.medicationfoundation.com/prog.aspx?o=state&a=OR&i=219
This group provides information on many programs. The Lane County program is for qualifying residents of Lane County, Oregon who lost their prescription coverage based on their survival priority level or as a result of the 2003 budget cuts.

THE NATIONAL COUNCIL ON AGING
https://ssl.benefitscheckup.org/
This site includes information on more than 340 different public and private programs aimed at (though not limited to) low-income Medicare beneficiaries, without Medicaid, who need additional assistance.

ROBERT WOOD JOHNSON FOUNDATION
http://www.rxassist.org
The RxAssist program provides qualified low-income individuals and families with access to generic versions of brand name medications.

MEDICARE
http://www.medicare.gov
Besides Medicaid, which provides assistance to people with little or no income, Medicare offers drug-discount cards. The current card system will be replaced on January 1, 2006 with a new drug prescription program for seniors: Medicare Advantage.

OREGON HEALTH PLAN
http://www.ehealthlink.com/OregonHealthPlan/Default.asp
The current Oregon Health Plan (OHP2, OHP/Medicaid) is one of the several State of Oregon financial assistance programs designed to meet the healthcare needs of low-income Oregonians. There are also the Children's Health Insurance Program **http://www.ehealthlink.com/OregonHealthPlan/CHIP.asp** (CHIP) and the Family Health Insurance Assistance Program **http://www.ehealthlink.com/OregonHealthPlan/FHIAP.asp** (FHIAP), the Insurance Pool Governing Board Program (IPGB), Oregon Medical Insurance Pool (OMIP), and the Oregon Prescription Drug Program (OPDP). The OPDP offers a prescription drug discount card for Oregon residents age 54 and older who meet other specific eligibility requirements. This program is also known as the Oregon Bulk Purchase Program.

Marie Godfrey