Prescription for the People
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The corporation Gilead owns the patent on sofosbuvir, the medicine that Sarah Jackson and millions of others with hepatitis C need. That patent awards the corporation a monopoly that allows it to set the price of sofosbuvir at whatever level the corporation believes the market will bear. Gilead has bet that the market will bear an astronomical price for a desperately needed medicine, and that bet has paid off, particularly in the United States, where aggressive pharmaceutical industry lobbying has blocked overall price regulation and even the ability of the government to negotiate the prices of the drugs it purchases itself.1 Gilead collected $12 billion in hepatitis C drug sales revenue in 2014, at least half of it paid by U.S. government agencies.2 That kind of income allows the company to pay John Martin, its CEO, as much as $180 million per year.3

The crisis caused by monopoly drug pricing is not limited to hepatitis C patients such as Sarah Jackson.4 There are many other examples of essential medicines being priced out of the reach of patients in the United States and in other wealthy nations. For example, spending on medicine
for diabetes, a disease diagnosed in 29 million Americans, is higher per
patient than any other traditional drug class, in part because more than
half of diabetes prescriptions filled are for patented drugs. The cost for
insulin lispro, marketed by the pharmaceutical corporation Eli Lilly under
the name Humalog, increased by 325 percent from 2010 to 2015. There
were only two other insulin manufacturers in the United States, Sanofi
and Novo Nordisk, and they also hiked their prices over 100 percent in
that time span. There is no generic form of insulin, and the lack of price
regulation of medicines in the United States keeps prices up to six times
higher than in other developed nations, a situation that U.S. Senator Jon
Tester (D-MT) labeled “price gouging, plain and simple.”

Not surprisingly, U.S. physicians report routinely seeing patients whose
lives are at risk because they cannot afford to use the prescribed amount
of insulin. A 2017 lawsuit alleging price collusion among the insulin
manufacturers includes reports of U.S. patients injecting expired insulin,
starving themselves to control their blood sugars, and intentionally allow-
ing themselves to slip into dangerous states of diabetic ketoacidosis so
they could get free insulin samples from hospital emergency rooms. In
low-income countries, the situation is even more dire. A diabetes patient
advocate reported a 2017 conversation with a physician in Cameroon,
who shared the story of a young patient’s father happily delivering news.
“Did you hear? Isabelle died!” the father said with a smile. He was refer-
ing to his diabetic daughter (the name here is a pseudonym), whose need
for insulin and equipment like syringes and blood sugar test strips had
plunged the family into financial distress. “Now we are all able to eat
enough, and the other children can get an education.”

In addition to insulin, similarly high costs are faced by U.S. patients
in need of medicine to address heart disease, high cholesterol, and infec-
tions. Vaccines are priced so high that one-third of U.S. family physicians
say they are considering ending their practice of offering vaccinations
because they cannot afford to buy them and keep them in stock. In 2015,
Turing Pharmaceuticals suddenly increased by 5,000 percent the price of
its anti-infection drug Daraprim. Overnight, the price rose from $13.50
to $750.00 per tablet, a spike that brought the annual cost of treatment to
as much as a half million dollars. From 2007 to 2016, Mylan Pharma-
ceuticals hiked the price of the lifesaving anti-allergy medicine EpiPen by
nearly 500 percent. Although the audacity of these price hikes generated
instant outrage—the two 2016 major-party U.S. presidential candidates called the Daraprim spike “price gouging” (Hillary Clinton) and “disgusting” (Donald Trump)—they were just extreme examples of the common industry practice.\textsuperscript{15} From 2012 to 2015, list prices on medicines made by large pharmaceutical corporations rose by over 12 percent per year, far exceeding the less than 2 percent annual rate of inflation over that period and also far exceeding the increase in other health care costs.\textsuperscript{16} In 2015, drug prices in the United States rose by almost 16 percent.\textsuperscript{17}

Those rising prices are a predictable result of the U.S. approach to medicines, which includes a unique combination of huge government spending on medicines paired with no regulation of medicine prices (a combination I explore more fully in chapter 15).\textsuperscript{18} The result is an environment with no price restraints. “Medicare is a huge, guaranteed market,” one industry observer says. “So the (pharmaceutical) companies are saying, ‘Let ’er rip!’ ”\textsuperscript{19}

So it is not surprising that U.S. patients pay the highest prices for medicine in the world, a per capita cost of about $1,000 per year.\textsuperscript{20} Consider this:

• A recent study showed that the median monthly price of branded cancer drugs in the United States was almost $8,700, compared with about $2,600 in the United Kingdom, $2,700 in Australia, and $3,200 in China.\textsuperscript{21}

• In the United States, medicines represent 10 percent of national spending on health and nearly 20 percent of spending in employer health insurance plans.\textsuperscript{22}

• Overall prescription drug spending in the United States is over $400 billion annually; global spending exceeds $1 trillion.\textsuperscript{23} Some European health systems, which unlike the U.S. Medicare program do negotiate drug prices, have even refused to pay for some high-cost medicines.\textsuperscript{24}

Ultimately, these whopping U.S. medicine bills are paid by the taxpayers who subsidize government health care programs such as Medicare and Medicaid. They are also paid by private health care systems, whose CEOs’ report that rising drug costs are undermining the finances of their companies.\textsuperscript{25} Increasingly, the costs incurred by those private companies are passed on to patients. Even when U.S. residents are covered by private insurance plans, those plans usually charge premiums and copayments,
and do not cover costs until a deductible threshold is met. In the last
decade, U.S. workers’ obligations for those health insurance premiums
rose 83 percent and their deductibles rose 255 percent, with 2016 testi-
mony to a U.S. Senate committee identifying prescription drug prices as
the biggest reason for those increases.\textsuperscript{26} One of the results of this crisis is
that medical debt has become the single largest cause of bankruptcy in the
United States.\textsuperscript{27}

As Sarah Jackson can attest, for many patients, the high cost of medi-
cines simply means that a doctor’s prescription goes unfilled. In a 2015
U.S. poll, 19 percent of respondents said they had recently not filled a
prescription because they could not afford the price.\textsuperscript{28} Another survey
reported that 50 million Americans each year skip taking prescribed med-
ication due to the cost.\textsuperscript{29} Predictably, there is a human price to be paid
for missing medications: multiple studies have shown that persons who
struggle to access prescribed drugs are at greater risk of heart attacks,
strokes, and other life-threatening health emergencies.\textsuperscript{30}

Even when patients do have adequate insurance coverage or can afford
to pay out of pocket the cost of the medicine they need, they often discover
that the medicine is still not available to them. In the United States, medi-
cine shortages are reported to be “the new normal,” with regular gaps
in the availability of essential antibiotics, cancer drugs, and anesthetics,
among hundreds of other medicines.\textsuperscript{31} In 2013, 83 percent of U.S. cancer
physicians reported not being able to provide a patient with the preferred
chemotherapy at least once in the previous six months. One-third of those
physicians reported having to delay treatment or exclude patients from
the medicine altogether.\textsuperscript{32} Reports of medicine rationing have been reg-
istered in the treatment of leukemia, ovarian cancer, bladder cancer, and
infections in need of antibiotics.\textsuperscript{33} Some U.S. physicians admit they delib-
erately avoid telling their patients that they are not getting the medicine
they need.\textsuperscript{34}

Like high prices, these shortages are the inevitable consequence of a
medicine system built on a foundation that relies on the motivations of
corporations seeking the highest possible profits. If pharmaceutical cor-
porations determine there is not sufficient money to be made producing
a medicine, especially compared to other products that they can charge
enormous mark-ups for, they have no incentive to make enough of the
medicines that have lower profit margins. The shortages are also spurred

\textsuperscript{16} Toxic Impacts
on by the secretive, exclusive character of the patent system, which leads to a limited number of manufacturers of the needed drugs.\textsuperscript{35}

Even if the medicines that are in shortage are potentially profitable to manufacture, “intellectual property” rights often trump patient needs. For example, when the Cleveland Clinic responded to a shortage of a blood-vessel surgery drug by mixing up its own version in-house, the clinic physicians wanted to share the formula with their colleagues facing similar shortages in other hospitals. But they discovered they could not do so: the Cleveland Clinic had claimed exclusive rights to the combination.\textsuperscript{36}

Sometimes drug shortages are the result of quality control issues in the medicine manufacturing process. But that problem too can be traced back to the for-profit nature of the industry because corporations see little urgency in fixing the manufacturing problem for a medicine that produces limited revenue. As a journalist who investigated drug shortages said, “Sometimes what happens is a [production] line goes down, something breaks down and a company, a producer looks at the margins and the economics and says ‘well, you know it’s not really worth the margins we’re getting on this drug in continuing the line—in putting the money in to fix it.’ So they let the drug go into shortage. And even if people need it—say it’s nitroglycerine which is critical in heart surgery—they just don’t produce it.”\textsuperscript{37}

Instead, for-profit pharmaceutical corporations inevitably focus their investments and their production capacity on medicines that provide a hefty profit. We have already read about one example: the hepatitis C medicine with a 500 percent mark-up (chapter 1). Not surprisingly, there have been no reported shortages of Sovaldi or Harvoni.