15. Taxpayers and Patients Pay Twice for Patented Medicines

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I once heard a former member of the European Parliament provide a colorful explanation of the problem covered by this chapter. When it comes to medicines, he said, governments are like really dumb venture capitalists. Governments pay to develop a product but then hand over that product to an outside organization, declining to take an ownership interest. What is worse, governments later agree to purchase the product they developed and pay marked-up prices due to a monopoly they gave the organization they handed the product to.

Of all the dumb medicines venture capitalists, none is dumber than the U.S. government. As we have seen in chapter 14, the U.S. government plays an indispensable role in funding the research that leads to the discovery of essential medicines. Until the 1980s, those taxpayer-financed breakthroughs were either owned by the federal agency that supported them or placed in the public domain, allowing patients to affordably access the medicines and researchers to build on the discoveries. But U.S. Senators
Birch Bayh (D-IN) and Robert Dole (R-KS), spurred on by pharmaceutical industry lobbyists, put a stop to that. They sponsored the Patents and Trademark Amendments Act, soon widely known as the Bayh-Dole Act, which allows universities and small companies that received federal research funding to claim patents for the discoveries that comes out of that research.²

Bayh-Dole went into effect in 1981, and universities and teaching hospitals wasted no time beating a path to the patent office. In the first five years under the new law, their human biology patent applications increased 300 percent.³ Universities also quickly began forming partnerships with small biotech companies and, ultimately, with the large pharmaceutical corporations to conduct late-stage research and then market and distribute the medicines. Those corporations were happy to buy the exclusive rights to government-funded discoveries—and the monopoly pricing powers that went with them.⁴

Simply put, this is a give-away of government-created resources. U.S. taxpayers, in particular, pay twice for patented medicine: first to subsidize the research and then by way of the monopoly prices charged to government programs such as the Veterans Administration, Medicaid, and Medicare. As we see later (chapter 20), pharmaceutical industry lobbying has even succeeded in making it unlawful for the U.S. government to negotiate down the medicine prices paid by Medicare.

This scheme has inspired outrage from physicians, economists, and health activists. They call the corporate-government medicines arrangement a “parasitic relationship.”⁵ Alfred Engelberg, a noted intellectual property attorney, laid out the terms of this relationship in the publication *Health Affairs* in 2015:

Federal law essentially socializes the cost of drug discovery while privatizing the profits since it does nothing to limit the prices that can be charged or the profits that can be earned from drugs discovered at public expense. . . . For decades, Congress has simply been transferring wealth from ordinary citizens to the pharmaceutical industry. While claiming to believe in free market capitalism, it has created a web of monopolies which cause the United States to pay the world’s highest prices for drugs even though it is the largest purchaser.⁶
Examples of these taxpayer-to-corporation wealth transfers are plentiful. Consider these few:

- The corporation Genzyme charges as much as $350,000 per year, ten times its manufacturing cost, for a drug to treat the rare Gaucher disease. That price is often charged to government programs such as Medicaid, even though the medicine was developed by the NIH.\(^7\)
- The corporation Amgen has billed Medicare for billions for the kidney disease drug Epogen, developed with taxpayer-supported research.\(^8\)
- The story is the same for the chemotherapy drug pacilataxel, developed with government research and now sold back to government programs at monopoly prices by patent-holding BristolMyersSquibb, who has branded the drug Taxol.\(^9\)
- NIH and U.S. Department of Defense funding helped develop the prostate cancer drug Xtandi, which is sold back to the federal government at over $100,000 per patient per year (a price that is two to four times that paid by patients in other countries), despite the fact that U.S. taxpayer dollars developed the drug.\(^10\)
- Even the $1,000-per-pill hepatitis C medicines (see chapter 1) owe their existence to government research. In fact, the drugs were developed in part using funding from the U.S. Veterans Administration. Now, that same agency faces cuts in its services because of the need to pay a corporate monopoly markup for these medicines.\(^11\)

The taxpayers-pay-twice arrangement is appalling, but it does provide an opening for the reform of our dysfunctional medicine system. As we see in chapters 20 and 21, there are many possible ways to make the medicine system better for both patients and taxpayers. At their core, these fixes would replace the waste and cost of the for-profit medicine model with approaches that rely on governments and nonprofits that answer to patients and taxpayers, not shareholders and corporate CEOs.

The good news is that the current government subsidy of the for-profit medicines model means there are plenty of funds to be shifted over to a system that will be both more effective and more fair. In his 2016 book, *Rigged: How Globalization and the Rules of the Modern Economy Were Structured to Make the Rich Richer*, the economist Dean Baker crunched
the numbers and estimated the money that could be saved if U.S. health care systems could provide medicines without the artificial price markup imposed by monopoly patents. It turns out that the resulting savings could fund the replacement of all private industry research and development several times over, replacing that private research with more impactful and transparent studies while still leaving billions of dollars in remaining public benefits.¹²