

Through the Looking Glass



A CAGW Special Report

PRICE CONTROLS ON DRUGS: HAZARDOUS TO YOUR HEALTH

By Elizabeth Wright
Assisted by Gerard Cox
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1301 Connecticut Avenue, NW Suite 400 Washington, D.C. 20036 (202) 467-5300
Internet Address: www.cagw.org

CITIZENS AGAINST GOVERNMENT WASTE

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Leslie K. Paige, Senior Vice President for
Policy and Communications

Citizens Against Government Waste
1301 Connecticut Avenue, NW
Suite 400
Washington, DC 20036
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Introduction

The Clinton/Gore Administration prescription drug benefit, which was first proposed in 1999 would lead to price controls and rationing of drugs for seniors. The price tag of the Clinton proposal, according to the White House, is \$253 billion over 10 years. But according to the Congressional Budget office, the cost is more in the range of \$338 billion.¹ The Republican counterpart bill in the House would cost less than half of that amount, totaling \$159 billion over the same period.² In actual experience, the cost is likely to be much greater. But whether or not the estimates are accurate, price controls are inevitable.

The Clinton/Gore Administration and supporting Democrats claim that their bill would not result in price controls. Although the bill might not call for outright price controls to be instituted over drugs, at the very least it furnishes an implicit price control mechanism. The president's plan does this by proposing that the Health Care Financing Administration (HCFA), the agency that oversees Medicare, select one contractor, or pharmaceutical benefit manager (PBM), for each of 15 defined geographical areas. Each PBM bidding for a contract will have to negotiate prices with drug companies, wholesalers and pharmacies; be able to administer claims and coordinate benefits; ensure a sufficient number of participating pharmacies; prove financial stability; and describe how it will deter medical errors.

Based upon the outcome of these results and negotiations, HCFA will then award the regional contract to the PBM with the lowest bid. This is clearly a form of price control although it may not be spelled out as such in the proposal. HCFA has the right to choose the PBM for each region and will undoubtedly weigh the bids in favor of the one that offers the lowest costs in drugs. There is even the possibility that one contractor could win the bid awards for more than one geographical region. Ultimately, what will be created is a monopsony in which the government is essentially the largest purchaser of a single commodity and therefore controls the price.

The Clinton/Gore Administration's proposal is inspired in large part by the supposed success of the Canadian healthcare system and its "cheap" prescription drugs. The latter has been a media darling for some time now, but closer scrutiny needs to be applied to Canada's healthcare system before it is given any more ringing endorsements. Various news reports³ and the book *Code Blue*, written by David Grazer, point out severe problems with the Canadian system. Long waiting lists to see specialists, limited medical

¹ Congressional Budget Office (CBO), *Analysis of the Health Insurance Initiatives in the Mid-Season Review*, July 18, 2000, p. 5. Available at: <http://www.cbo.gov/showdoc.cfm?index=2252&sequence=0&from=5>, Accessed Sept. 28, 2000.

² CBO, *Cost Estimate on H.R. 4680 – Medicare Rx 2000 Drug Act*, June 28, 2000, p. 1. Available at: <http://www.cbo.gov/showdoc.cfm?index=2160&sequence=0&from=6>, Accessed Oct. 12, 2000.

³ See: *The New England Journal of Medicine*, June 29, 2000; *The Cincinnati Enquirer*, March 9, 2000; *The Globe and Mail*, Jan. 5, 2000; *The Washington Post*, Dec. 18, 1999.

technology and delays in getting surgery and access to new lifesaving pharmaceuticals are commonplace.

It is important to note that the president's prescription drug benefit, and most of the alternatives introduced in Congress, would be added to the current Medicare program as a stand-alone benefit. The danger of such a benefit is that it is vulnerable to the problem of adverse selection, or the possibility that only heavy users of prescription drugs will opt for coverage, dramatically increasing the cost of the insurance. Those seniors with high drug costs are a minority of the elderly population, as 72 percent of seniors spend less than \$500 annually out-of-pocket on drugs and 51 percent spend less than \$200.⁴ It should be also noted the average senior spent more on going out to eat (\$1,192) and on entertainment (\$1,044) in 1998 than on drugs (\$670).⁵

These figures also prove there is not the "crisis" in prescription drug coverage that some politicians would have you believe. This does not mean, however, that there is no problem. Many seniors have expensive drug bills and desperately need help. Medicare does need to modernize and provide private prescription drug coverage. But imposing price controls to assist a minority of seniors would end up being disastrous for the majority of seniors, and in fact, all Americans.

History warns us that price controls always have unintended economic and social repercussions beyond their intended effect of stabilizing prices at a certain level. As shown in this report, price controls at best have a subversive impact as suppliers evade them and set up black markets; at worst they have a disastrous impact, causing shortages that are incurred by the controls themselves.

Price Controls: A Misguided Business

Price and wage controls are not a recent phenomenon. Indeed, price and wage controls have been recorded since ancient times and have continued to the present day, despite their questionable results. In their book *Forty Centuries of Wage and Price Controls*, authors Robert Schuettinger and Eamonn Butler detail the expansive history of price controls and their various effects.

From the Babylonian "Code of Hammurabi" some 40 centuries ago, with its stringent wage requirements and prices for all market transactions, to the Nixon price controls of the Economic Stabilization Act, Schuettinger and Eamonn show how price controls constantly crimp economic progress and distort the market, undermining the signals of supply and demand necessary to achieve price equilibrium. Without price equilibrium – the price that buyers and suppliers can agree to on equal terms for a given commodity or product – the market goes into disarray and becomes distorted, and it does not matter what commodity is affected. One can expect to see alternative bartering systems develop, such as shadow or black markets, with a corresponding increase in prices,

⁴ Michael E. Gluck, *A Medicare Prescription Drug Benefit*, National Academy of Social Science, April 1999 ~ No. 1, p. 2. Available at: <http://www.nasi.org/Medicare/Briefs/medbr1.htm>, Accessed: Oct. 28, 1999.

⁵ Bureau of Labor Statistics, "Consumer Expenditure Survey, 1998." Available at: <http://www.bls.gov/sahome.html>, Accessed Oct. 12, 2000.

demand, shortages, diversion of resources into areas not under price controls, regulations, and sellers pursuing other business.⁶

Pioneering Price Controls in the U.S. to the Point of Starvation

An early American experience with price controls is illustrative of the disruption they cause. The first wave of New England colonists attempted to fix wage rates. In Massachusetts, the General Court made the decision that carpenters, joiners, bricklayers, thatchers, and lawyers were to receive no more than 2 shillings a day, and additionally “no commodity should be sold at above 4 pence in the shilling (33 percent) than it cost for ready money in England...” This policy was both counterproductive and short-lived, lasting only about six months.⁷

The following passage, written by an early historian, William Weeden, relates a similar effort by the colonists in their trading relationship with the Indians, which also failed:

There was an attempt about the same time to regulate trade with the Indians...with the same result. The price of beaver-skins [an important article of trade at that time] was set at no more than 6 shillings a skin with a “fair” profit of 30 percent plus cost of transportation. A shortage of corn, however, drove the price of that commodity up to 10 shillings “the strike,” and sales of this dwindling supply to the Indians were prohibited. Under this pressure, beaver advanced to 10 shillings and 20 shillings per pound: “no corn, no beaver,” said the natives. The court was obliged to remove the fixed rate, and the price ruled at 20 shillings.⁸

Yet even failed experiments with price controls did not deter the colonists from renewing their efforts towards achieving “fair” prices. The Commonwealth of Pennsylvania implemented price controls on commodities being used by the Continental Army. Although the goal was altruistic – lower costs to taxpayers in supplying the army – it had disastrous results. At the time the price controls were implemented, General George Washington’s army happened to be stationed for the winter at Valley Forge. The price controls had a most perverse effect for Washington and his men; the only success of the controls was almost starving the army. Farmers held back much of their crops, as they regarded the prices at which they had to sell them to be unfair.

Due to the harmful results of that Pennsylvania effort to control prices, the Continental Congress on June 4, 1778, resolved to have no further price controls. The resolution was as follows:

Whereas...it hath been found by experience that limitations upon the prices of commodities are not only ineffectual for the purposes projected, but likewise productive of very evil consequences to the great detriment of the public service and grievous oppression of individuals...resolved, that it be recommended to the

⁶ See: Robert Schuettinger and Eamonn Butler, *Forty Centuries of Wage and Price Controls – How Not to Fight Inflation*, The Heritage Foundation, Washington, D.C., 1979.

⁷ *Ibid.*, p. 38.

⁸ *Ibid.*, pp. 38-39.

several states to repeal or suspend all laws or resolutions within the said states respectively limiting, regulating or restraining the Price of any Article, Manufacture or Commodity.⁹

It is clear from this resolution that price controls were found to be both counterproductive and “evil” by early Americans. Unfortunately, American leaders in recent history have failed to heed the warning of our ancestors. The price controls of the Nixon and Carter Administrations are prime examples of the obstinate belief in the value of price controls that continues to defy both reason and experience.

The Nixon Wage and Price Controls

Under authority of the Economic Stabilization Act of 1970, President Nixon was able to regulate all wages, prices, rents and interests in order to control inflation. Price controls were implemented twice – in 1971 and 1973 – and finally ended in 1974, while controls on oil lasted until 1981. The price controls of the Nixon era had a broad array of odd, distorted, and otherwise unintended effects, which Nixon realized far too late. He said:

What did America reap from its brief fling with economic controls? The August 15, 1971, decision to impose them was politically necessary and immensely popular in the short run. But in the long run I believe that it was wrong. The piper must always be paid, and there was an unquestionably high price for tampering with the orthodox economic mechanisms.¹⁰

Perhaps the most striking impact of Nixon’s decision was the kind of evasive action that took place due to price controls. For example, with price controls on all of the typical cuts of beef, grocers circumvented controls by inventing new cuts of beef, such as the so-called “watermelon roast,” which did not fall under price controls. Another example was the tactic employed by lumber producers in which they took advantage of a loophole for imported lumber, which was exempted from price controls. They simply exported lumber to Canada and then imported it back into the United States. Another tactic was to take advantage of yet another loophole for “customized” work. Enterprising contractors drilled holes in wood, then filled the holes back up again to create a customized product.¹¹

Herbert Stein, Chairman of President Nixon’s Council of Economic Advisors, warned Nixon in the spring of 1973 that to implement price controls again would be disastrous. But Nixon did it anyway. In addition to the almost comical responses above, there were other far more onerous results. Cattle were withheld from the market, driving up the cost of beef; baby chickens were drowned; food shelves were sparse.¹²

⁹ Schuettinger and Butler, p. 41.

¹⁰ President Richard Nixon, *The Memoirs of Richard Nixon*, Grosset and Dunlap, New York, N.Y., 1978, p. 521.

¹¹ Steve Mufson, “Price Controls: Past as Health Care Prologue; Clinton Would Find a History of Failure, Unintended Effects,” *The Washington Post*, March 14, 1993, p. H1.

¹² Herbert Stein, *Presidential Economics: The Making of Economic Policy from Roosevelt to Clinton*, American Enterprise Institute, Washington, D.C., 1994, p. 186.

Stein succinctly reflected on the economic policy at that time: "As I think back on that period, we didn't do that much good. The trend of prices...slowed down, but within a few months after the controls were over we were back to the previous trend."¹³

The Oil Crisis

During the 1970s, inflation began to take its toll on the American economy. The nation could no longer continue to afford the massive social programs created by the Johnson Administration and the continued military involvement in Vietnam without cutting government programs or raising taxes. This inflation weakened the dollar internationally. The international monetary system was based on a gold exchange standard and the U.S. based the dollar to a specified amount of gold. Other countries then tied their currency to a fixed exchange rate with the dollar. By 1971, the pressure on the dollar became unbearable. Nixon abandoned the gold exchange standard.¹⁴ Then a Democratic Congress enacted the Economic Stabilization Act to control prices and wages. Nixon's use of that act to impose wage and price controls created shortages in all areas of the economy, including the domestic oil supply.

In response, the United States met its oil needs with imported oil because controls were placed on domestic oil prices. The end result was that the amount of foreign oil used by Americans rose from 25 percent in 1971 to 33 percent by 1973.¹⁵ It was then that OPEC was encouraged to interrupt oil supplies as punishment to countries that were supportive of Israel.

The Nixon price controls helped to create the crisis that President Jimmy Carter's activist response only worsened. By 1977, Carter hoped to control inflated prices by restricting oil imports from foreign countries with tariffs and quotas. His "regulatory tax" at the pump and on gas-guzzling automobiles was aimed at driving down gas consumption, which in turn was supposed to control inflation. It did neither.¹⁶ Fuel prices skyrocketed again, and Americans were waiting in line for their gas.

There were other consequences to the gas shortages that resulted from government interference in regulating gas prices. Hoarding and a distortion of the market became commonplace. Some individuals bought large quantities of gas and stored them in large containers. It was even reported that the late singer John Denver constructed two 100-gallon gas tanks on his Colorado estate. Gas tank "topping" was a routine occurrence and gas stations often restricted the amount of gas one could purchase at one time.¹⁷ Red and green flags displayed to indicate whether the gas station had gas were commonplace and odd and even numbers on your license plate determined which days you could buy gas. There were anomalous geographic disparities: ample gas in one area, and long lines in

¹³ Mufson, p. H1.

¹⁴ Edward L. Morse, "A New Political Economy of Oil?," *Journal of International Affairs*, Sept. 22, 1999.

¹⁵ William Tucker, *How Rent Control Drives Out Affordable Housing*, Policy Analysis # 274, CATO, Washington, D.C., May 21, 1997, p. 6.

¹⁶ Theodore Lowi and Benjamin Ginsburg, *American Government: Freedom and Power*, W.W. Norton Company, New York, N.Y., 3rd Edition, 1994, p. 618.

¹⁷ Tucker, p. 7.

another. Some people began to think that waiting in lines for gas would be very much a part of their future.

When President Ronald Reagan came into office, one of the first things he did was remove oil price controls and abolish some 200 energy regulations. Within one year, oil consumption and prices fell and domestic oil production increased for the first time in more than 10 years. Reagan simply allowed market forces to control the price and supply. Richard Minitzer, an environmental policy analyst at the Competitive Enterprise Institute, put it more candidly: "The policy that is no-policy produced no gas lines or fuel shortages."¹⁸

Rent Control Equals Fewer Rentals

Rent control has been used for many years around the world, usually as a temporary measure to help tenants during a real or supposed housing shortage. Britain, Sweden and British Columbia, Ontario and Alberta, Canada and parts of the United States have all tried – and some continue to use – rent control to keep prices down and provide "affordable" housing for low-income individuals. It is a popular measure because it immediately pleases housing activists and provides political cover for elected officials (more than half of all households in urban areas are tenants). And, because rent control doesn't "cost" the government anything, the majority of taxpayers are not affected. Unfortunately, the negative effects are not felt until years later, usually when the politicians who implemented the measure are long gone from the political scene.¹⁹

When they impose rent controls, municipalities, in response to political realities and in order to reduce the housing shortage that would be produced, often allow an unregulated sector to exist in the overall market. New York City, for example, has 63 percent of its apartments – 1.1 million units – regulated under price controls. This places approximately 2 million individuals into regulated housing and at the same time forms a strong political constituency within the city that obviously favors maintaining the status quo.²⁰

The unregulated market in New York City is about 600,000 units, which creates a shadow market. As prices in the regulated market go lower, the prices in the shadow market go higher. Finally, this difference in prices reaches a point at which those living in the regulated market begin to hoard their apartments – they never move. If they do move, black markets are often created in which the tenant simply sublets the apartment to a friend or relative for a higher rent, paying the landlord what is owed and pocketing the rest. Or the tenant may sublet the apartment to strangers for "key money," a sum of money that actually more accurately reflects the true value of the apartment. Therefore, very few regulated or price-controlled apartments ever make it to the newspaper listings.²¹

¹⁸ Richard Minitzer, "The Oil Shortage That Wasn't," *National Review*, April 15, 1991, p. 38.

¹⁹ Edgar Olsen and M.A. Walker, *Rent Controls, Myths and Realities – International Evidence of the Effects of Rent Control in Six Countries*, eds. W. Block and E. Olsen, Fraser Institute, Vancouver, B.C., Canada, 1981, pp. 268-269.

²⁰ Tucker, p. 4.

²¹ Tucker, p. 14; Bruce Lambert, "Higher Stakes in Eviction Battles," *The New York Times*, May 8, 2000, Available at: <http://www.nytimes.com/00/05/08/news/national/regional/ny-evict.html>. Accessed May 8, 2000.

Rent control encourages housing to deteriorate. Landlords find it difficult to get a decent rate of return on their investment so they fail to repair damage or fix problems, causing the housing to depreciate at a faster rate. It is simply a way landlords rationalize and deal with the value of their property.²²

Rent control increases the demand for housing while at the same time reducing the profitability of rental housing, reducing the supply. Rent control creates a disincentive to build new housing units that fall under its regulations. For example, if the rent control regulation exempts housing units with fewer than a certain number of apartments, such as duplexes or 2–3 unit owner-occupied buildings, the end result is more of those types of units are built and large housing units that fall under the price control regulations are not. In New York City, for example, the price control regulation exempted all housing built after 1969. New apartment buildings were constructed until inflationary pressures forced the city to break this pledge and include all apartment buildings. Builders and potential owners soon learned that it was very likely that all new apartment buildings would eventually be “recaptured” under price controls, and therefore, apartment construction essentially stopped.²³

Rent control can also result in perverse responses, especially when the city realizes that rent control does not work and is trying to implement a form of deregulation called “vacancy decontrol.” For example, the regulation may state that the apartment must remain under rent control only until the current tenant leaves. This creates a situation in which some landlords try all sorts of subversive, even corrupt, means to evict current tenants, such as hiring people to burn their buildings.²⁴

Sadly, price controls on rental units do not really help the poor and, in many cases, others learn how to manipulate the system. For example, in many college communities in past years, rent control activists, with the help of student voters, were able to implement price controls for rental housing. In many cases, the students who lived in the regulated apartments while attending college are still there years later – as working professionals making high salaries. It is quite common in cities across the nation with rent controlled housing to find that the middle class occupies its regulated units. The poor, unable to find housing, are forced to leave and live in communities without rent control.²⁵

Let's Try Price Control for Drugs?

One of the biggest debates in Washington, D.C., is providing a prescription drug benefit for Medicare recipients. Most people agree that Medicare should provide some sort of prescription coverage, but question how it should be done. The Clinton/Gore proposal, which does not specifically mention the words “price controls,” will undoubtedly lead to them.

²² Olsen and Walker, p. 273.

²³ Tucker, p. 11.

²⁴ *Ibid.*, p. 16.

²⁵ *Ibid.*, p. 9.

But it is not only the Clinton/Gore proposal that will implement price controls. Other politicians have introduced bills for Medicare drug benefits that use the same mechanism to provide low-cost drugs to seniors. These are some of the more prominent bills:

H.R. 664, Prescription Drug Fairness for Seniors Act of 1999.

This House bill, introduced by Rep. Tom Allen (D-Maine), has the stated intent “to provide for substantial reductions in the price of prescription drugs for Medicare beneficiaries.” It would force drug manufacturers to make Medicare-covered drugs available for purchase by pharmacies at the price equal to or less than the lowest price paid for the same covered outpatient drugs by any agency or department of the United States Government.

S. 2464, The Prescription Drug Fairness Act

This Senate bill, introduced by Sen. Slade Gorton (R-Wash.), amends the Robinson-Patman Anti-discrimination Act with the intent to “protect American consumers from foreign drug price discrimination.” Effectively, this bill would call for a leveling of drug prices between the United States and other countries. It would order drug companies to sell their products in the United States at prices no higher than the selling prices of the drugs in another country. If a drug company violates this requirement, it would be liable for damages.

Fiscal Year 2001 Agriculture Appropriations

Re-importation/importation amendments were added to Food and Drug Administration (FDA) funding to allow wholesalers/pharmacies to import any prescription drug approved by the FDA from selected foreign countries. While the goal is to take advantage of lower priced drugs in other countries, it is highly unlikely these savings will be passed on to consumers because most of the drugs will need new packaging and labeling. Other concerns with the legislation include whether foreign counterfeit drugs will be allowed to enter the U.S. with greater ease and in larger quantities than they do now.

CAGW’s report *A Better Prescription for Seniors*, points out that the Clinton/Gore plan favors universality over adequacy of coverage. This encourages the belief that all seniors need to look to the government for drug coverage. Once the senior has been lured into the government-run prescription plan, private drug coverage plans will disappear. At that point, seniors will depend entirely on politicians and bureaucrats for their drugs with nowhere else to turn. Unfortunately, once seniors are locked in, they will realize the inadequacy of the program and try to get more coverage for their prescription drugs. The long-term result will be an expensive taxpayer-funded program for all seniors that will grow at astronomical rates. It will only be a matter of time before price controls are implemented, just as they have been for other services in Medicare today.²⁶

²⁶ John Hoff and Elizabeth Wright, *A Better Prescription for Seniors*, Citizens Against Government Waste, Washington, D.C., March 27, 2000, p. 5.

As mentioned earlier, the Clinton/Gore plan will divide the country into 15 geographic regions and Medicare will contract with one pharmaceutical benefit manager for each area. The PBM will be chosen based on its ability to control drug costs, provide disease management programs, and build relationships with drug manufacturers. It will not be long before the government demands that the PBMs keep drug expenditures within certain limits; in other words, price controls.

What kind of market responses could we expect if the Clinton/Gore Administration got its wish and price controls were implemented for prescription drugs? We just need to look north of the border to Canada for an answer.

Canadian Healthcare: An Inspiration for Mediocrity

The inspiration for the Clinton/Gore drug benefit and its imitators undoubtedly comes from the Canadian healthcare system's purported success with its price controls on prescription drugs. Some members of Congress have even taken busloads of senior citizens across the U.S./Canadian border to take advantage of low drug prices. Canada's healthcare is the latest pet example promoted by some politicians and health advocates on how healthcare should be delivered. By many accounts, Canadian citizens are supposedly very happy with the quality of their healthcare. But a closer look reveals that Canadian healthcare is not quite as consumer-friendly as it has been portrayed.

One only needs to review Canadian newspapers to discover what their healthcare system is truly like. In January 2000, *The Globe and Mail* reported that Canadian emergency rooms were overwhelmed due to "too few acute-care nurses, not enough long-term care beds, limited medical care for nursing-home patients, and the scarcity of doctors and clinics during weekends and holidays."²⁷

Michael Bliss, a professor of history at the University of Toronto, wrote how ill Canadians find themselves

... in the clutches of a deteriorating system of shortages, queues, demoralization, excuses and profound cruelty. It is a system created without regard for principles of elementary economics, and sustained by ideologues wildly out of touch with the real needs of Canadians. It is desperately in need of fundamental reform; as every day passes more of our citizens are condemned to conditions of care that are disgraceful in a rich country in 2000.²⁸

In *Code Blue*, David Gratzner systematically points out how the Canadian healthcare system is deteriorating. His book takes a close look at the economics involved in Canada's medicare system, which are at the core of the nation's healthcare woes. Because patients don't know the expense of services and doctors have the incentive to provide more services than are necessary, there is over-utilization and skyrocketing costs.

²⁷ Krista Foss and Andre Picard, "ER Crisis Deepens Across the Country," *The Globe and Mail*, Montreal, Canada, Jan. 5, 2000, p. 1.

²⁸ Michael Bliss, "Sick and Tired of It," *National Post*, Toronto, Canada, Jan. 12, 2000.

Unlike a private market system, which uses competition to control costs, the Canadian government restricts access to new technologies and drugs and uses price controls.²⁹

In 1984, the current form of Canadian healthcare was ushered in with the proclamation that it would be “universal, portable, comprehensive, and accessible.”³⁰ But in examining the Canadian system on the basis of its own criterion, it is apparent that the system has not been able to live up to its goals.

Is the Canadian system “universal”?

No. Canadian health bureaucracy in fact has a very narrow “provincial” outlook. Two provinces, British Columbia and Alberta, require their residents to pay premiums or they are not covered. Other provinces require that residents register in order to receive coverage. Many citizens don’t receive coverage simply because they are not willing to wade through the bureaucracy or they are unable to afford the premium.³¹

Is it “portable”?

No. Healthcare benefits available to residents within their home province do not transfer equally to another province. For example, a Quebec resident who becomes ill in another province must first pay out of his or her own pocket for treatment and will only be reimbursed for what the service would have cost in Quebec. Finally, Canadians abroad are not covered for all of their treatment costs and frequently confront huge health bills.³²

Is it truly “comprehensive”?

No. It is only comprehensive if one is willing to concede that each provincial government only pays for treatments it determines are medically necessary. Citizens under 65 may find that many surgeries and pharmaceuticals are not covered, and those over 65 may only get partial coverage.³³

Is it “accessible”?

No. This is where Canadian healthcare system fails most critically, as rationing and long waiting lines for treatment are endemic to healthcare in Canada. For example, even though Canada was ranked fifth in 1997 by the Organization for Economic Cooperation and Development (OECD) for national health expenditures, the same organization ranked Canada in the lowest third of its 29 member countries for availability of devices such as MRI and CT scanners. Canada clearly has a paucity of available medical devices in its hospitals relative to its size and wealth as a nation. Ironically, many Canadians have to

²⁹ David Gratzner, *Code Blue – Reviving Canada’s Health Care System*, ECW Press, Toronto, Canada 1999.

³⁰ The Fraser Institute, *Canadian Health Care – A System in Collapse*, p. 1. Available at: <http://www.fraserinstitute.ca/publications/backgrounders/20000127/index.html>, Accessed Sept. 28, 2000

³¹ *Ibid.*

³² *Ibid.*, pp. 1-2.

³³ *Ibid.*, p. 2.

cross the border to receive important medical treatments, such as chemotherapy, that are commonplace in the United States.³⁴

Drugs in Canada – Getting What You Pay For

William McArthur, M.D., former chief coroner for British Columbia and health policy analyst in Vancouver, warns Americans that things are not what they appear to be when it comes to accessing prescription drugs in Canada. He states that Canada's approach to drug therapy mirrors its approach to healthcare in general: drugs are controlled by a centralized, bureaucratic system that uses rationing and price controls to restrain their use. According to McArthur, this process routinely and "purposely restricts the overall availability of prescription drugs through a combination of a lengthy drug approval process and oppressive price controls. The result is patients are often harmed."³⁵

For example, few Americans probably realize that a large portion of Canadians pay for their drugs themselves. In Canada's 10 provinces, only elderly, poor and long-term care patients receive subsidies for their drugs. Only four of these provinces provide some coverage to the rest of the population. In the other six provinces, the general citizenry must pay out-of-pocket.³⁶

In addition, the provinces use other avenues to restrict access to prescription drugs. The country's federal approval process takes an average 13 percent longer than the U.S. process. And although the Canadian government looked at approximately 400 drugs between the years 1994 and 1998, it decided that only 24, or 6 percent, offered substantial improvements over previously approved drugs. Some drugs approved in the United States never win Canadian approval and therefore cannot be purchased by its citizens.³⁷ For example, the drugs Detrol®, Aricept®, Singular®, Accolate®, which are used to treat Alzheimer's disease, asthma, and urinary incontinence and are breakthrough drugs, were available in the United States in 1998 but not in Ontario.³⁸

Once a drug wins federal approval, it must then go through a separate "approval" process for each province. A review committee in each province looks at the drug and decides whether it will be placed on the provincial formulary – the list of drugs the provincial government will pay for or subsidize. Times to approval vary greatly from province to province. For example, after a drug receives federal approval, it takes Nova Scotia 250 days, almost eight months, to list the drug on its formulary. Ontario takes even longer, at 500 days, or one year and four months. Some provinces may choose not to list the drug at all on their formulary.³⁹

³⁴ The Fraser Institute, p.2.

³⁵ William McArthur, MD, *Prescription Drug Costs: Has Canada Found the Answer?*, Brief Analysis No. 323, National Center for Policy Analysis, Dallas, TX., May 19, 2000, p. 1.

³⁶ *Ibid.*, p. 2.

³⁷ *Ibid.*

³⁸ Pharmaceutical Research Manufacturers of America (PhRMA), *Backgrounders- The Canadian Health Care System: Delays in Access to Medicines and New Medical Technology Draw Criticism and Harm Patients*, Washington, D.C., Available at: <http://www.phrma.org/publications/backgrounders/world/canadadelay.phtml>, Accessed Oct. 30, 2000.

³⁹ McArthur, p. 2

Canada uses price controls to ration the supply of drugs to its citizens. The board that oversees prescription drugs negotiates the final price rather than using competition and market forces to keep prices down. Theoretically, with his or her own money, a Canadian citizen can purchase a drug that is approved by the federal government but is not on a province's formulary (and therefore not subsidized). But because this market is so small, pharmaceutical manufacturers are not inclined to sell such drugs widely. The end result is that Canadian citizens cannot get a drug until a year or longer after American citizens have it.⁴⁰

Further scrutiny into Canada's pharmaceutical market verifies Dr. McArthur's claims. One will find that the provinces exclude the newest and most costly treatments from their formulary lists. In Ontario, for example, the provincial government added only 25 of the 99 drugs approved by the Canadian federal government in 1998 and 1999. The province routinely denied its residents access to the newer and better drugs for osteoporosis, Alzheimer's disease and Parkinson's disease simply to control costs.⁴¹

Finally, at a Healthcare Leadership Council briefing in the U.S. Capitol, Durhane Wong-Reiger, Ph.D, President and CEO of the Anemia Institute for Research and Education in Canada, cautioned attendees to beware of price controls for pharmaceuticals. She pointed out that when a drug ends up on a province formulary, it will automatically end up on private insurance formularies. But if the drug is not listed on a province formulary, it is more difficult to get the drug on private plans.

Dr. Wong-Reiger stated that Americans with private insurance have far greater access to drugs with various levels of co-payments than Canadians who have private plans. She commented: "The bad news is that those who rely on government-funded drug plans have very limited access to the best medicines. For those who think the solution to universal drug access is through price controls, you need to know: patients in Canada do not have access to newer treatments." She went on to say, "It is my experience that ANY healthcare program whose bottom line is cost control will not effectively serving [sic] patients. In Canada, we have found that the bureaucrats that manage drug plans are preoccupied with costs. Therefore, when faced with more effective medicines that cost a bit more versus older, cheaper, less effective medicines with more side effects, they will always choose the lower cost drugs, regardless of the impact on patients."⁴²

Why Price Controls for Drugs Must Be Avoided at all Costs

It has been largely demonstrated that any good accomplished by price controls in the short run is more often than not outweighed by distortion and disarray in the marketplace in the long term. Price controls almost always have unintended repercussions throughout the economy, beyond their immediate intended impact of stabilizing the price of a product or commodity.

⁴⁰ McArthur, pp. 2-3.

⁴¹ Laura Dykes, "Adverse Reaction: Why the United States Should Not Adopt Price Controls for Prescription Drugs," Pacific Research Institute for Public Policy, *Action Alert #56*, San Francisco, Calif., Sept. 20, 2000, p. 1.

⁴² Durhane Wong-Reiger, Ph.D, *Drug Benefits and Price Controls – Learning from Experience*, Presented at the Healthcare Leadership Council Conference, Washington, D.C., May 22, 2000.

Taking another close look at the supposed low cost of prescription drugs in Canada, one finds that on average, drug prices in Canada are actually higher than in the United States. Patricia Danzon, the Celia Z. Moh Professor at the Wharton School, University of Pennsylvania, undertook a comparative study on the prices of drugs in various countries. Looking at the weighted price of drugs, she found that a U.S. consumer would actually pay an average of 3 percent more for his or her drug in Canada than he or she does in the United States. (A weighted price takes into account the frequency of use of a particular drug.) She also found that U.S. citizens would pay 27 percent more in Germany, 44 percent more in Switzerland, and 9 percent more in Sweden. In some countries, U.S. citizens would pay less, such as in France or Italy, which also have strict price controls. But by and large, prices of drugs in the United States are far from being the highest in the industrialized world.⁴³

The explanation for this surprising fact is that most analyses of U.S. drug prices typically leave out generic drugs. In the United States, generics account for some 46 percent of all prescriptions. Some countries, such as Italy and France, use strict price controls for branded products. Their generic drug markets are very small because they have no price-sensitive customers who would be attracted to low-cost generics.⁴⁴

In light of their stringent price control systems, it is not surprising that France's contribution to global drug research is a measly 3 percent, while Italy's is even less. The United States contributes about 45 percent of the world's new drugs. Our closest competitor in drug research is the United Kingdom, which contributes 14 percent.⁴⁵ It is the free market in the United States that allows us to be the world's leader when it comes to valuable research and development. But if price controls are implemented in our drug market, then soon we too will do less research. Not only will we suffer; the entire world will suffer with us.

Many of the problems caused by price controls throughout history could easily happen to the prescription drug market. Indeed, some of these problems are occurring in the drug market right now, albeit not yet within our own borders. Consider this: Just as Americans once stood in line for price-controlled oil in the '70s, Canadians now wait for prescription drugs to be put on their provinces' price-controlled formularies.

We've seen how meat cutters in the 1970s marketed new cuts of beef that would not fall under Nixon's price controls; how rent control created disincentives to build new housing units, causing housing shortages and shifting costs to the unregulated housing market; and how price controls on domestic oil discouraged oil exploration in the United States. If price controls are placed on pharmaceutical companies, they too will research, manufacture and market drugs that are not geared to seniors and therefore, do not fall under Medicare's jurisdiction.

⁴³ Patricia Danzon, "Making Sense of Drug Prices," *Regulation*, Vol. 23, No.1, 2000, p. 57.

⁴⁴ *Ibid.*, p. 58.

⁴⁵ PhRMA, *Why Do Prescription Drugs Cost So Much?*, June 2000, p. 16.

What also needs to be pointed out is that since the elderly are only 12 percent of the population but account for approximately one-third of all drug spending,⁴⁶ there will be cost shifting. Drug companies will need to raise the price of non-price controlled drugs in an effort to recoup their research and overhead costs.

The oil industry is very comparable to pharmaceuticals in that the oil industry spends millions of dollars in exploration and often comes up with a dry well. Although modern technology can help to improve the odds, historically, new field wildcat oil exploration has taken five to 10 wells drilled before one well is found that produces oil. Those dry wells must be paid for.⁴⁷

In the pharmaceutical industry, of 5,000 chemical compounds researched, only five on average actually make it into the clinical trial phase. Of those five, only one actually makes it to the marketplace. Revenues from successful medicines must cover the costs of the pharmaceutical "dry holes" or the research will not be done. The average cost of bringing one new medicine to the market is \$500 million.⁴⁸

Price controls and a complicated government manipulation of both domestic and foreign oil upset the marketplace and forced us to rely on OPEC, which resulted in long lines at the gas pumps when OPEC began its embargo.⁴⁹ Placing price controls on pharmaceuticals will discourage pharmaceutical "exploration" and years later we will have fewer new drugs. Essentially, we will be standing in line hoping for a new discovery to cure our illnesses.

What's the Answer?

Medicare is based on a 1960s model of healthcare delivery. At that time, pharmaceuticals were not an important part of healthcare. Hospital stays and surgery were critical, and Medicare pays for those procedures. But now Medicare is slow to recognize new treatments, particularly in the area of medical devices. Unlike healthcare today, which focuses on prevention, Medicare focuses on acute, reactionary care.

The importance of drugs in our healthcare has changed. Outpatient expenditures on drugs have almost doubled between 1990 to 1998. According to John Calfee, a resident scholar at the American Enterprise Institute, we are not actually seeing an increase in drug prices, but an increase in utilization of drugs. He points out that since 1993, the prices of pharmaceuticals have been increasing at a rate of 4 percent a year, just slightly above the inflation rate. The largest portion of the increase in drug costs is due to increased volume and a movement toward newer, and more expensive, drugs. But these drugs prevent or reduce expensive surgery or other medical procedures. For example, H2

⁴⁶ National Economic Council-Domestic Policy Council Press Release, *Disturbing Truths and Dangerous Trends*, The White House, Washington, D.C., July 22, 1999, p. 5.

⁴⁷ U.S. Department of Energy – Office of Fossil Energy, *Environmental Benefits of Advanced Oil and Gas Exploration and Production Technology*, Oct. 5, 1999, p. 28.

⁴⁸ PhRMA, p. 2.

⁴⁹ Stein, pp.190-192.

antagonists, such as Tagamet®, have reduced the costs of surgery for ulcers by more than half.⁵⁰

In light of these changing needs, it is important that seniors have prescription drug coverage if they want it and feel they need it. But before politicians simply add a drug benefit to the current structure of Medicare, one should pay close attention to the words spoken by Sen. John Breaux (D-La.), chairman of the National Bipartisan Commission on the Future of Medicare, at the commission's final meeting:

The issue of revenue and solvency was one of the most difficult issues the Commission faced. As I've said before, I think putting surplus dollars into the Part A Trust Fund doesn't fix Medicare's underlying program. I've likened it to putting more gas in an old car – it still runs like an old car and doesn't have any of the features of a new car. In fact, I share the concern expressed by the GAO Comptroller last week in testimony before the Senate Finance Committee that giving the Part A Trust Fund an infusion of treasury securities could undercut the incentives to engage in meaningful and fundamental reform. We can't ignore the need to fundamentally reform Medicare and we need to do it sooner rather than later. If we thought it was difficult to address reform two years ago during BBA [Balanced Budget Act], imagine how much harder it's going to be if we wait until 2008 or 2009 when the baby boom generation is on the verge of retiring – at that time they will represent nearly a quarter of the population.

Extending the life of the Part A trust fund by transferring treasury securities from one column to another without doing anything to fix the underlying problems gives people the impression that we don't need to do anything else to Medicare because Part A is solvent until 2020. That is simply not true – we DO need to restructure Medicare and I will continue to make that case long after the Commission ends its work.⁵¹

CAGW agrees that Medicare needs to be modernized. The program should be restructured to make it work more like the health plan that is used by federal employees, members of Congress and the president and vice president. That plan is the Federal Employees Health Benefit Plan, or FEHBP. It is also the plan that was recommended by a majority of members on the Bipartisan Medicare Commission, headed by Sen. Breaux and Rep. Bill Thomas (R-Calif.).

FEHBP gives government workers the freedom to choose from a variety of competing private plans. The government does not set the price of any component of care covered by the private plans. The plans simply compete on how efficiently they can provide health insurance, allowing competition and choice to keep costs down. According to a recent Executive Branch Office of Personnel Management (OPM) press release, the average increase in premiums in FEHBP was 8.5 percent for HMO plans and a 10.9 percent premium increase in fee-for-service plans for a weighted average of 10.5 percent.

⁵⁰ John Calfee, *Prices, Markets, and the Pharmaceutical Revolution*, AEI Press, Washington, D.C., 2000 pp. 5-10.

⁵¹ Senator John Breaux, Chairman, Opening Statement, The Bipartisan Commission on the Future of Medicare, March 16, 1999. Available at: <http://rs9.loc.gov/medicare/breaux31699.html>, Accessed Oct. 16, 2000.

This is 2 percentage points lower than increases seen in the private-sector market, where employees generally do not have a choice of health plans.⁵²

Furthermore, all of the plans in FEHBP provide drug coverage with a variety of co-payment and deductible arrangements. Drug coverage is unlimited, which protects beneficiaries from high or catastrophic drug costs.⁵³ The drug coverage is integrated with all the other healthcare services, unlike the Clinton/Gore plan that adds a completely separate drug benefit with a separate premium to Medicare.

Instead of adding an expensive drug benefit to the current financially shaky Medicare structure that will only cover 50 percent of a senior's drug expenditures (until one reaches \$4000 in out-of-pocket costs)⁵⁴ while imposing price controls – as the Clinton/Gore plan does – wouldn't it be better to model Medicare after a health plan that has been proven to work? After all, if FEHBP is good enough for President Clinton and Vice-President Gore, it should be good enough for our seniors.

⁵² OPM News Release, "OPM Announces 2001 FEHB Program Rates," Sept. 15, 2000, Available at: <http://www.opm.gov/pressrel/2000/fehb%20open%20season%202000.htm>, Accessed Oct. 13, 2000.

⁵³ The choices available under FEHBP are set out in *The Washington Consumers' Checkbook, Guide to Health Insurance Plans for Federal Employees*, prepared each year by Walton Francis and the Center for the Study of Services, Washington, D.C.

⁵⁴ The White House, *Improving The President's Medicare Prescription Drug Benefit and Provider Payments*, Washington, D.C., June 26, 2000, p. 2. Available at: http://www.whitehouse.gov/New/00BudgetFramework/budget_improvemedicare.html, Accessed: Oct. 30, 2000.