Tuesday, January 27, 2004

Dr. Milton Friedman
Nobel laureate

Congressman Gil Gutknecht
(Republican, Minnesota)

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Transcript of Health Care Debate-Fairmont Hotel

[After the panelists were introduced, the debate proceeded as follows:]

Glassman: The system controls the price of drugs through what economists call monopsony or the power of a single purchaser to set prices. And according to speaker Dennis Hastert, "Threats to steal the patents of drug companies." There's no doubt the drug prices in Canada are lower than they are here, but the important issues are these: If importation is allowed, will price controls and then the entire Canadian system be exported to the United States? Will prices actually fall or will middlemen capture the difference between costs and market prices?

And will, as many have said, US drug companies which now make the vast majority of drugs, as the rest of the world free rides on American research, simply reduce their research and go to make other kinds of medicines on which they might be able to make more money under a different regime, including generics and patent medicines or small modifications of existing drugs? In addition, we will examine broader issues of health policy. In an article in 2001, Milton Friedman, one of our panelists today wrote that since the end of World War II the provision of medical care in the United States has displayed three important features.

First, rapid advance in the science of medicine, second, large increases in spending, and third, rising dissatisfaction with the delivery of health care. Both on the part of consumers and on physicians and other suppliers. Today's debate is a manifestation of all three of these features. And these are important, serious issues. Unfortunately much of the debate to this point on these questions has been characterized by over-simplification and demagoguery and I am sure that will not be the case today. Let me introduce our panelists. Milton Friedman to my left received the Nobel Prize in economics in 1976, and the presidential medal of freedom in 1988.

He taught for 30 years at the University of Chicago, where he led a counter-revolution in economic thinking against predominant Keynesianism. He then moved to the Hoover Institution at Stanford. His work on the quantity of money has made an enormous impact on his profession, but he may be best known as a lucid advocate of free markets and personal liberty, especially with his books, "Capitalism and Freedom," published in 1962 and the remarkable TV series, "Free to Choose," also a book, which had a big impact on a lot of people, including me. I first heard him lecture 38 years ago when I was a freshman in college. Milton Friedman lives here in San Francisco with his wife, Rose Director Friedman, also a distinguished economist with whom he has co-authored several of his books. And I am sure he will not mind if I tell you that he turns 92 in July.

Representative Gil Gutknecht represents the first district of Minnesota, to my right. He was first elected to Congress with the wave of Republicans that captured the house in 1994. He supposed Newt Gingrich's Contract with America, but he has since parted company with many of his colleagues on the issue of prescription drug importation on which he is the chief advocate I would say in Congress. He is chairman of the house agricultural sub-committee on operations oversight, nutrition and forestry. He's the vice chairman of the science committee and a senior member of the budget committee.

Sally Pipes, to my far left has been president and CEO of Pacific Research Institute since 1991. She specializes in issues of health care, economics and education. She's a regular columnist for Tech Central Station as well as having written many op-eds and other pieces for newspapers around the country, including here in San Francisco recently on this issue. Don McCanne to the far right received his MD from the University of California at San Francisco in 1963. He practiced for more than 30 years in San Clemente, California and has served as chief of staff for his community hospital. He's dedicated many years to speaking and writing on behalf of universal health care and has served as president of Physicians for a National Health Program in 2002 and 2003. Thank you for coming up from San Juan Capistrano.

Thank you, Congressman Gutknecht for coming up from Rochester, and I myself came here from Washington, which was quite a pleasure since it's a big mess right now, not just politically, but weather-wise. Here's the format: I will ask questions, panelists will provide answers. Any panelist who really kind of feels that he or she urgently wants to make a brief intervention, raise your hand and I'll call on you. We will have about 45 minutes of discussion up here, and then we'll take questions from the floor. PRI personnel are circulating with cards on which you can write questions. We'll also invite questions from our listening and I think even viewing audience around the country.

Let me start with Dr. Friedman. You are the ultimate free market pro-capitalist economist in the world. I think that is not an understatement. Some people say that if something is cheaper somewhere else, let's import it into this country. But the question of price controls does complicate matters. Do you favor the importation or re-importation of pharmaceuticals from Canada?

Friedman: My initial reaction when I first was asked this question was to say yes. But the more I've thought about it, the more I've come to the belief that it's not an issue of free trade at all, and that the right answer is not re-importation. And now I don't know how much you want me to expand on that or—

Glassman: A little bit more than you just did.

Friedman: --you want a simple answer.

Glassman: I know you signed a statement with 140 other economists in opposition because of this issue of price controls. Maybe you could explain that, why you feel this is a different case and is not a case of free trade.

Friedman: Oh, it's not a case of price controls, that isn't the issue, either. The issue is patents. The issue is a government-granted monopoly and whether that, how extensively the rights that are granted for that purpose extend. The real issue is not really re-importation. The real issue in my opinion is the Food and Drug Administration. The FDA in the United States has followed policy, which means that it costs roughly $800 million to bring a single new drug entity to the market. And the question is where is that $800 million going to come from? The answer that we have given, whether the right answer or the wrong answer, the answer we have given is that it's going to come by giving the producer of the drug a patent, a monopoly privilege to sell that drug, to exclude others from the sale of that drug.

And the question is are you going to enforce that exclusion? The only way in which that $800 million can be raised is by charging very high prices to some people.

Now, the question is given that you're charging those high prices to some people, is it okay to charge low prices to some people? This is a standard case of a monopoly which engages in price discrimination as a way of maximizing its income. It charges high prices where the elasticity of demand is low, it charges low prices where the elasticity of demand is relatively high to the citizens of other countries. Consider the following case: Suppose somebody in Canada simply counterfeits a patented drug. Does free trade require that the US accept importation of that drug?

I think the answer's no, if you're going to enforce the patent, you have to keep out such counterfeits. Well, fundamentally and from an economic point of view, essentially when drugs that are purchased in the United States under a contract that they will be sold in Canada, or instead shipped to the United States, that's the same thing. That's violating the patent law. And the question is should the US government enforce one aspect of the patent and not another? That's the real issue. There's no denying the fact that prices are cheaper in Canada. But the purpose of the law, the purpose of the patent was to enable the patent owner to make enough money to pay for the cost of producing the drug. And that's not going to be possible unless you have price discrimination.

And price discrimination adds to human welfare, it permits a larger number of people around the world to have the drug than it could otherwise do so.

Glassman: So last question: So the consequence of eroding the regime that does not allow importation of drugs from Canada and other countries would be that the money for research would disappear, is that what you're saying?

Friedman: Absolutely, it would disappear or it would have to be provided some other way. And as I say, the real issue in my opinion is the FDA, which has made the costs of approving a drug intolerably high. It never was that high, the number of new drugs that are being produced each year is going down and has been going down as the cost has gone up. People say that it's the drug companies that want to prevent re-importation. It is, of course, but fundamentally it's the FDA that has to do so.

Glassman: Congressman Gutknecht, in a press release on this session you are quoted as saying, "We import everything from pork bellies to plantains. There's no justification for holding Americans captive in a pharmaceutical market that forces them to pay three, four, five or even 10 times as much as our friends in Canada and Europe." Now, you represent the first district of Minnesota, an area where I know the agriculture is important. You have a lot of dairy cows in your district. Let's just imagine this situation: Canada controls the price of milk and provides subsidies to farmers, and as a result the price

of milk in the United States is three, four, five or even ten times as much as it is, we pay three, four, five or even ten times as much as our friends in Canada.

Would you favor free importation of milk? And what would be the consequences to your constituents?

Gutknecht: Well, Jim, thank you for that loaded question. [laughter] Let me step back just for a minute and thank Sally and PRI for doing this, and let me also say how much I admire Dr. Milton Friedman. Part of the reason I got into politics was watching videos, well, they weren't videos then, they were actually films of "Free to Choose." And I've been a big fan of his ever since. Now, he said in his introductory remarks he at first was in favor of importation, and the more he looked at it, the more he decided to be opposed to it. My view is somewhat different. I was originally opposed to the idea of importation, of price controls. But the more I studied it, the more I came to a different conclusion. And if I could, I feel a little like the little boy who came in and asked his mother a question, and his mother was busy and she said, "Go ask your Dad."

And the little boy said, "Well, I didn't want to know that much about it." [laughter] And sometimes I feel like that little boy, I'm not sure I wanted to know this much about it. Now, one of the numbers that gets bandied about, and it comes from the pharmaceutical industry, is that it costs $800 million to get a new drug approved in the United States. No one has ever audited those numbers, and there are many independent experts who say those numbers are wildly exaggerated. But I got into this issue, and I don't want to take too long on this, but I got involved in this issue originally at a, I think it was a town hall meeting in Fairbold, Minnesota and there were seniors there who were telling me about their bus trips going up to Canada to buy their drugs.

And at that time, you know, I didn't really like, I guess I was on the other side and said, "You know, I don't think this is necessarily a good idea, but I'm certainly not going to stop them." So I just let the issue sort of drop. And then a few years later, something happened that was totally unrelated to prescription drugs. The price of pigs in the United States, to get back to your example, the price of pigs in the United States collapsed. My largest employer is a little medical practice that was started by two brothers named Mayo. They now employ 25,000 people in my district. But the second largest employer is a little company down in Austin, Minnesota where every day we turn 16,000 pigs into Spam, the world's finest lunchmeat that comes in the blue cans. [laughter]

But in any event, this was a catastrophe. The price of live pigs dropped from about $37 per 100 weight down to about $7. Now, my pork producers could not afford to feed their pigs, they couldn't afford to slaughter their pigs. This was a calamity not seen in

the pork industry since the Great Depression. Now, what made it even worse at that time, to get back to Mr. Glassman's example is that literally thousands of pigs were coming across the border every day from Canada. This was called NAFTA, it's called free trade. And many of my pork producers started calling and said, "At least could you do something to stop all of these pigs from coming in from Canada making our supply and demand situation even worse?"

So as their Congressman I called the Secretary of Commerce and I called the Secretary of Agriculture and I got essentially the same answer. They said, "That's called free trade, that's called NAFTA, those are free markets. If Canadians want to send pigs across our border, they're free to do that." And it was then that a light bulb went on over my head and I said, "Wait a second, you mean we have free markets when it comes to pork bellies, but not when it comes to Prilosec?" And literally, the Secretary of Commerce sort of chuckled on the other end of the phone and said, "Well, I guess that's true." And that's sort of where my whole pilgrimage began, was the price of pork bellies.

And the more I studied the differences between what Americans pay for prescription drugs and what the rest of the industrialized world pays for those same drugs, the more I came to the conclusion that if markets work with pork bellies, they will work with Prilosec. And I am a believer in markets. There's a famous Californian who became president by the name of Ronald Reagan who's one of my big heroes. And Ronald Reagan once observed that markets are more powerful than armies. And let me get back to this patent issue, and I know that Dr. Friedman is aware of this, but every country that joins the WTO must first sign what's called a TRIPS agreement. And the TRIPS agreement says that you cannot steal peoples' patents or intellectual property rights.

What we are now practicing in the United States I think is best described as prescription exceptionalism, because I believe in intellectual property rights. And I understand that when Intel comes out with a new chip, that first chip may cost them $500 million, and the next chip may cost them ten cents, and they have to figure out a way to blend that cost over the production of those chips. But what we don't permit Intel to do and we don't permit anybody else to do and we don't permit pork producers to do is to protect themselves in this market alone. In other words, if we were selling those chips to Japan for one price and to somebody else for another price, we don't say that the distributors in those other countries can't sell back into the United States.

Now, my vision is not that Americans will go online and buy their drugs from Canada or Germany or any other country. My vision is that you will open up markets and ultimately prices will level. Now, we are a blessed country, and frankly I think Americans should pay more for prescription drugs than people in developing countries like

sub-Saharan Africa. I think we ought to subsidize those people in sub-Saharan Africa. But I do not believe that we should be required to subsidize the starving Swiss. It is time for the Swiss to pay their fair share. Now, we can talk a little bit about how pharmaceuticals are priced in other countries. I have a report here from York University in England, which goes through several of the countries in Europe and really delineates how they actually determine what the prices are.

And it's not exactly what the pharmaceutical industry has told us. And if we have time, we'll get into that—

Glassman: Let's try to answer the question that I asked, which was about I think an analogous situation. If you don't think it is, then say that. Price controls or subsidies in another country, let's say Canada reduce the price of milk by a substantial amount. The Canadians want to send that milk into the United States to compete with your farmers in Minnesota. Is that okay with you?

Gutknecht: Well, no, that's not okay with me, but let's understand: They do not subsidize pharmaceuticals in Canada. They don't subsidize pharmaceuticals in Germany. I have a little handout here, and if we could, we'll hand this out to you, and it has a chart, and Dr. Friedman has already conceded the central point, and that is that Americans pay a lot more. And let me just give you one example. The drug Tamoxifen, Tamoxifen is a miracle drug. It is probably the most effective drug we have ever come up with in terms of the treatment of women's breast cancer. And I always tell people that breast cancer doesn't just affect women, it affects everybody in the family. And we pay in the United States, the average price for a 30-day supply of Tamoxifen is $360.

In Munich, Germany you can buy that drug at the Munich Airport pharmacy, and that's actually where we bought the drug, for $60 American. Now, the thing that really [frosts] me about that is that you, the taxpayers paid for virtually all of the research, the US taxpayers to develop that drug, Tamoxifen. We literally took it all the way through phase two trials. And the reward that Americans get is we pay six times more for the Germans, who didn't pay anything for the research. And so at some point I think we do have to come to a conclusion that, you know, we cannot have a system where we continue to subsidize the rest of the world, especially when we're spending 15% of our gross domestic product on health care and the rest of the industrialized world is spending—

Glassman: Just one really quick question: Why isn't the solution then to put pressure on the rest of the world to stop controlling their drug prices, to stop acting as monopsonists and to stop subsidizing, and in fact to join the free market that we have in this country?

Gutknecht: Well, first of all—

Glassman: Rather than doing something which almost certainly will lead to, some people believe to the non-development of the kinds of drugs that you just described.

Gutknecht: Well, if we simply opened up markets, markets work, they will level prices. Prices in the United States, in my opinion, if you simply opened up markets and allowed what they have in most of Europe, called parallel trading, if you allowed parallel trading to exist in the United States, and it's done safely in virtually every country in Europe today, if you opened up those markets, what you would see is a leveling of prices. The pharmaceutical companies would be forced to charge higher prices in those countries and significantly lower prices here in the United States.

Glassman: We'll get to Dr. Friedman on that subject. My guess is he will probably disagree. But Sally Pipes, let me ask you about Canada, because there may be some misconceptions. You are an actual Canadian. [laughter] Let me ask you two quick questions. One is what's the difference between importation and re-importation? Because I don't quite understand that. And second, on Canada are there, why are prices lower in Canada than they are in the United States?

Pipes: Well, first, it is important to distinguish between importation and re-importation. Re-importation refers to drugs that are manufactured by the pharmaceutical companies here in the US and are approved by the FDA. They are then sold to Canada and there is a system which I'll talk about, The Patented Medicines Prices Review Board, which is the body in Canada that sets the prices of the drugs that they're going to put on the various formularies that each province has. Those same drugs, which are re-imported, that are imported into Canada are now being re-imported back into the United States and sold to individuals. And as Jim mentioned, some cities, some counties, some governors are looking into re-importing American drugs through Canada.

The second point refers to importation. Importation is drugs that are manufactured in countries around the world, not to FDA standards, but then end up in Canada and are being imported into the US. These drugs, for example in an operation that the FDA and US customs did in September, in the analysis of 1,153 drugs, 88% of them were deemed to be counterfeit or not up to FDA standards. The other point being that 15% of those drugs that came in actually were from Canada and were US drugs that went to Canada. But 13% came from India, 8% came from China, so we had a problem with counterfeit drugs. So that's the difference between importation and re-importation. Canada's pharmaceutical industry is an $8 billion industry.

That is very small relative to the United States. They have 31 million people in Canada, and here in the US we have almost 300 million people. When Governor Blegoyavitch in Illinois is talking about importing all of the drugs for his state employees and his Medicaid recipients, he's talking about $2 billion worth of imported drugs. Now, as I mentioned, the Canadian industry is $8 billion. So a quarter of the Canadian drugs would be being re-exported to the United States, which I think just is not feasible. Jim, the other point that I would talk about is in Canada, under the Canada Health Act, prescription drugs are not part of the Canada Health Act, but they are subject to government control. The Patented Medicines Prices Review Board is the health Canada agency which decides which drugs are going to get onto the formulary.

On average, the Therapeutic Practices Directorate, which is the version of the FDA in Canada takes 39 days on average longer to approve a drug in Canada which has already been approved in the US by the FDA. But with the price control system in Canada, for example between 1997 and 1999 only 43 out of 100 drugs that were approved for use here in the US made it onto the Canadian formulary because the government determined that the price for these drugs was too high. We often hear about politicians talking about Americans, seniors going to Canada to get their drugs. How often do we hear about the Canadians who come to the United States to get drugs that they can't get?

And I've had many emails and calls from AIDS victims in Canada who would love to get Rayitaz and the new T-20 inhibitor drugs, and they are just not available. I called the Therapeutic Practices Directorate to find out where this drug was in their review process, and they said they couldn't tell me, but it wasn't yet in review. So Canadians are suffering from drugs that aren't available like Embrel and Remicade for arthritis and some of the new hepatitis C drugs, Copagis and Pegasis. So there is a system of price controls in Canada, and Canadians on average earn lower incomes. So AOL sells their service at a lower price in Canada than it does here in the US, because we do have to cover the cost of producing.

And I look at it in some way like the airline industry. After the airlines in the US have covered the cost of getting a plane in the air, their average cost, just like in pharmaceuticals, then they sell seats at discounted prices. And some of us take advantage of those discounted prices. But if everybody's going to fly at the discounted price, no, but the plane will not be taking off. So I think the real issue, as Jim mentioned is price controls are bad for people in the US, and I think that we really need to focus on getting rid of price controls in Europe, in Canada, in Great Britain. And the EU and Great Britain have recently been talking about removing price controls on drugs.

Glassman: Dr. McCanne, as a physician do you have concerns that if drug importation and re-importation forces down prices, that drug companies will cut back research, as some people, as Sally has just said and as Milton Friedman has said, and that ultimately Americans will not be able to get the life-saving medicines that they have been getting over the last many decades?

McCanne: Well, first of all I'd like to say that our perspective is not in playing rhetorical games about free markets versus the government. We're concerned about the fact that Americans do not have adequate access to health care and drugs more specifically, because of the way we fund health care. And I think we may get into that later. But that's the major thrust behind our proposals. We don't think that we really need to re-import drugs from Canada, except maybe as a temporary measure. We think we need to import Canadian drug prices. And every other nation has some mechanism of controlling excessive prices. And we need to do the same thing. In Medicare we do that for physicians, hospitals, laboratories. And now that we've accepted prescription drugs as a part of Medicare, we need to do that with the prescription drug industry as well.

Now, the question about suppressing research, much of the research that is done by the pharmaceutical industry is to produce drugs that restart the patent clock. 80% of new drugs provide very little value compared to what we're spending in health care. We need research, but a lot of that is done through the National Institutes of Health that we're paying for anyway. We do need new products. There are a lot of gaps in advances in research today, but the pharmaceutical industry is not being responsive to those gaps. They're going to where the money is. New patents to produce drugs that are copycat drugs or are in a time release form or something like that, which merely extends the outrageous pricing that we have. Pharmaceutical firms spend more than twice as much on marketing and administration than they do on research.

That marketing is a big waste, because they're trying to convince doctors that these newer drugs are much better drugs when there's very little evidence for that. We need to get them to cut their marketing down to reasonable marketing so they're informing physicians and the public on the real issues instead of the phony marketing of their expensive products, and we need to get them to provide value in their research activities. And we could save a lot of money on pharmaceutical costs there.

Glassman: Thank you. Let's now, after this first round try to keep answers short. I'm going to get back to Dr. Friedman. I want to ask a quick question to Congressman Gutknecht. In the statement that was signed by Milton Friedman and 140 other economists in November of last year, it says, "The ideal situation would be for other wealthy nations to remove their price controls over pharmaceuticals. America's the last major market without

these controls. Imposing price controls here would have a major impact on drug development worldwide." The first sentence I read, the idea solution would be for other wealthy nations to remove their price controls over pharmaceuticals. Do you agree with that?

Gutknecht: Not completely, and the bottom line is this: When you have the government playing a much larger role in the purchase of health care. In fact, and it's not just government, it's large insurance companies. We have third-party reimbursement for most Americans. It may not all be run by the government, but the direction we're heading unfortunately is for more of that. But I do agree with Dr. McCanne on this, that we have a situation where when you look at how drugs are purchased, right now Americans are in the worst of all worlds. I mean we don't have the government negotiating on our behalf. Now, some insurance companies negotiate on our behalf to get lower prices. But the most troubling statistic that I came across, and I spoke last spring to the National Association of Pharmacists, and I had just gotten this number from the Kaiser research people.

And they found that 29% of seniors say that they have had prescriptions that went unfilled because they couldn't afford them. I asked the pharmacists that day, I said, "How many of you have had this happen, where someone brings a prescription in to you, they hand it to you, you tell them how much it's going to be, and their head sort of drops and they say, 'Well, I'll be back tomorrow,' and they never come back?" That is almost indefensible, and the big reason is because the prices that we pay. And I have to also agree in terms of when people say, "Do you think the research will go away?" That's a little like my farmers saying, "Well, if we can't make at least a 20% rate of return, then we're not going to plant our crops next year."

Now, I'm not one who believes that we ought to restrict the amount that the pharmaceutical industry can spend on advertising, but let's look at the numbers. You know, in testimony before one of the subcommittees—

Glassman: Actually, we're really going to try to keep things short, because we've got to move on. I think the question was clearly about is the ideal solution for other wealthy nations to remove their price controls over pharmaceuticals, yes or no?

Gutknecht: Well, that may be an ideal solution, but it's not going to happen.

Glassman: Let's move on.

Gutknecht: And in Washington you have to deal with what can be done, and what can be done is open up markets and it will force the other countries and the companies to readjust their pricing strategy.

Glassman: Dr. Friedman, do you think, Congressman Gutknecht just said the best way to get drug prices down is to have the government negotiate on peoples' behalf. Do you think that's the best way to get drug prices down?

Friedman: No, I don't think that would get drug prices down. But I want to go back to the other point. It would be desirable for wealthy nations to eliminate price controls. But so far as the issue we're talking about today, that would not affect that issue one bit. You would still have the situation that a pharmaceutical company produces a drug, that drug involved a lot of cost in developing it. It has to get that money back. It's going to charge a high price at home. It will in its own interest want to sell abroad as well. Should it be prohibited from charging a lower price abroad than at home? I don't think anybody would say it should. But then in that case, the same issue would arise. The company makes a contract with a Canadian importer. That contract is, "We will sell you this drug at this lower price, provided you agree not to re-import it into the United States."

Should that contract be enforced? That's a fundamental issue, and the existence of price control or no price control really doesn't affect it.

Glassman: And your main point is that the companies would not have the incentive to do the research, whether it's $800 million or $500 million, or whether companies spend more on marketing than the Congressman and Dr. McCanne would like, they won't spend that money to develop new drugs if that property right is not preserved in the way you're talking about.

Friedman: Well, they will do the research, they will spend money, but not as much, they won't do the same kind of research. They can't. Where do they get the money? Unless you have government subsidization, which is not a solution that I think is desirable.

Glassman: Sally, let me bring you into this. On this issue of third-party reimbursement, specifically how does it work in Canada? Is there a free market for drugs in the sense that individuals can go to the drug store and go to this drug store or that drug store where the prices are different, they can go to an insurance company that's different. How much competition does actually exist?

Pipes: Well, in Canada, as we'll probably talk about in a few minutes, Medicare, all health care is covered by the government. It's unlike Great Britain, there is no

private insurance that is allowed under the law to run parallel to government insurance. However, under the Canada Health Act, prescription drugs are not considered medically necessary, so don't fall under the Canada Medicare Program. However, 50% of drug purchasing in Canada is done through the government for seniors, for people on low income and things like that. So 50% is run by the government. Now, companies which don't provide health insurance like employers do here in the US do in their benefit packages now provide prescription drug coverage through private insurers like Blue Cross and Blue Shield.

So most companies, most people working in Canada today get their drugs using their insurance, through their private insurance plan.

Glassman: Dr. McCanne, I know that you wanted to talk in more general terms. Maybe we can just touch on this and I'll come back to Dr. Friedman and Congressman Gutknecht, and then we'll go to the questions. You were saying that you don't think the big problem is importation of prescription drugs, it's a much broader issue. Essentially you want the United States to adopt the Canadian system or something close to it.

McCanne: On our broad issue of universal health insurance, yes, we certainly believe that we need to use our resources much better than we do. We spent $1.6 trillion this last year on health care. That's more than enough to provide comprehensive health care for absolutely everyone in this nation. But we have the most wasteful system in the nation. Our administrative costs are outrageous, and it's primarily because of our fragmented system, the way we fund health care through multiple private plans, public programs and no programs at all. And the administrative burden that that places on the health care delivery system. And if we recovered that waste, and we've shown that we could recover about $280 billion, that would pay for comprehensive health care for everyone.

So we think that it's time for us to adopt a national health insurance program.

Glassman: Dr. Friedman, how did we get to the health care system that we have now, which appears to be somewhat inefficient? Maybe you could give a little history.

Friedman: It is extremely inefficient. You know, fundamentally there are only two ways to produce and distribute any economic product. One is top-down command and control, the other is free market, private enterprise, voluntary agreement among individuals. That's the other way. We got into our situation in a curious way. Believe it or not, a major part of our present difficulties arose from wage control in World War Two. That's a very strange statement offhand, and yet it's true. The reason is that during World War Two, wages were being held down under wage control, and we inflated. Naturally that created a

demand for workers. And in order to try to attract workers, employers not being able to raise wages started offering side benefits.

And the side benefit of medical control, of providing health insurance, health care proved to be extremely attractive, and tended to spread. And of course, the employers did not report that as part of the income for tax purposes, which they should have done. When the IRS woke up about three years later and started asking employers to report that, everybody had already been taking it for granted that that was a privilege of employment, and they raised the devil and Congress passed a law making it tax-exempt. The result is that if you get your medical care in the United States through your employer, you don't pay income tax on it. It comes out of before-tax income rather than after-tax income.

On the other hand, if you buy insurance for yourself, up to now, unless what President Bush has asked for in his State of the Union message goes through, you pay for it out of after-tax income rather than before-tax income. And that's what introduced third-party payment. Before World War Two, most medical transactions were between a patient and his physician or caregiver. As is the case, for example when you buy food or clothing or health or other things. And again, before World War Two, insurance meant the same thing in health as it did in other areas. When you insure your car, you don't expect the insurance company to pay for your gas. But when you have health insurance today, you expect your insurance company to pay for your prescriptions, for ordinary care.

And the reason for that, again as I say is because of the intervention of the development of the situation under which health care was provided by employers. That led to third-party payments, so that a typical transaction is not between a patient and his physician, but involves a third party, an insurance representative, somebody who has to certify that this is right. The physician no longer is working for the patient, he's working for the insurance company or for the government or some other third party. And that has led to the enormous increase in bureaucratization, to the enormous increase in expense. And it's not a system that works. And the way to get out of it is to move back toward first-party arrangements.

Fortunately, one big step has been taken in the Medicare bill that was passed. That's the provision of health savings accounts, medical savings accounts. These are accounts which extend tax exemption to individual personal health arrangements under which they set up an account that is tax-exempt. And that will be completed if President Bush's proposal to exempt catastrophic insurance from income tax goes through. But that's how we got into this situation.

Glassman: So ultimately this was a tax problem, and that would probably be the best way to fix it, but it may be very difficult to do that. You've written that health care is at least as important as food, and we don't have such a thing as food insurance that's paid for by our employers.

Friedman: I can guarantee if we did, look, that's going back to the company town. How many people remember when you had a situation in which workers in isolated communities would get their food, their housing and everything else from their company? They would be paid in kind rather than in cash. But medicine is the one area that's left in which in general people are paid in kind rather than in cash.

Glassman: Congressman Gutknecht, do you really think that prices will go down if we have re-importation from Canada? I mean, think of it this way: Let's say that a drug costs $30 in the United States and $20 in Canada. It's then re-imported back into the United States. The basic rules of supply and demand would say that nobody's going to charge $20 for it here. Maybe they'll charge $29.95, but it would be absurd for someone to sacrifice the $10 in profit. So the $10 will get captured by a middleman. Some people feel that advocates such as you are kind of selling Americans a kind of strange bill of goods here. The prices will not decline simply because the cost of the good somewhere else is lower than it is here.

Gutknecht: You may be right. At the end of the day, that's not our job. I mean ultimately the market will sort that out. And the problem is that we have distorted the market by giving the pharmaceutical industry artificial protection here in the United States. And can I simply come back another point? Because there is this mid-understanding about how other countries derive their prices. In the York report, and if I could, I'd just like to read a couple of sentences here.

Glassman: Okay.

Gutknecht: The Netherlands, for example. The first line of the study, and incidentally this study was paid for by the European Association of Euro Pharmaceutical Companies. And the first sentence says, "Until 1996 the Netherlands allowed pharmaceutical manufacturers the freedom to set the prices of their products." And then it goes on, they made a slight change recently, and then it goes on to say, "A manufacturer is still free to set the price higher than at the reimbursement level." But the difference is, as they go on to say, and this is true in Germany and the United Kingdom and many other countries, essentially what those countries do is they determine how much did it really cost to produce this drug?

What were the research costs, and what's a reasonable amount of profit? And then they determine, that's how much they will reimburse their subscribers. The

pharmaceutical companies can charge whatever they want in those countries. But what happens is the consumer has to pay a significant co-pay. Let me give you one example.

Glassman: I'm not really clear on that. You say that they decide what the price of the drug ought to be based on the cost to produce the drugs?

Gutknecht: No, they determine how much they will reimburse the subscribers of the insurance plan. If you are a British citizen, you are a member of the British health care plan and you have a card, and you can go and buy drugs at the local pharmacy, and they can charge whatever they want. But you will then only be reimbursed what the government has determined to be a reasonable amount. But if you want to pay a $50 co-pay on Prilosec or Cumetin or whatever, that's their option. But the pharmaceutical companies have found that markets do work, and consumers do have a resistance to large co-pays. And so effectively that price becomes the price.

Glassman: So you're saying that the markets in Europe are freer than in the United States?

Gutknecht: Well, I wouldn't quite say that, and I don't think I did say that. But they're not exactly what the pharmaceutical companies have led us to believe. I want to come back to something also that the doctor said next to me. That is in terms of the way the research is done and how the research is paid for, and what actually is being done, let me give you an example: And you talk about the advertising. If you have not seen a Nexium ad in the last 30 days, you have not been watching television or reading magazines. Nexium is the next version of Prilosec, and Prilosec is a very effective drug against acid reflux disease. But here, by their own research, the company that developed Nexium, and the reason they developed it is Prilosec was going off patent.

And here in the United States, and I believe in patents, as I said earlier, I believe in intellectual property rights, but it was going off patent. Prilosec sold on average for about $120 for a 30-day supply. It was going off patent, so the company needed a new blockbuster drug because it's a multi-billion dollar drug for the company. They came out with Nexium. Now, by their own research it's only about 2% more effective than Prilosec, but they don't say that in their ads, do they? Now that Prilosec has gone off patent, you can buy it for as low as $12 for a month's supply. Nexium sells for about $130. Now, when we hear that Canada has not put that on their formulary, there's a reason. Because they have determined that that is not cost-effective for their consumers for—

Glassman: But you—

[End of Side A / Begin Side B]

Glassman: Do you support price controls on prescription drugs?

Gutknecht: No, no, I say let the market work. Why protect the—

Glassman: The market is working in the United States, a lot of people would say.

Gutknecht: Glaxo in public testimony last fall admitted that last year, in 2003 they spent $3.9 billion on advertising. These are for products that you cannot buy without a doctor's prescription. I'm not here to tell them whether they can spend $3.9 billion in advertising, that's their business. I'm not even going to tell them what they can sell their drugs for in Germany or the United Kingdom, that's their business too. But when they start saying we're going to have a differential price for us compared to the rest of the industrialized world, then it becomes as a public policy maker, my business. And all I'm saying is we're not going to protect you any longer.

If you make a market decision to spend this amount of money on advertising, if you make a market decision that you will sell that product in the United Kingdom, then we will not protect you from that decision. Because we are going to have to deal with the way the rest of the world buys health care one way or the other. And we will either deal with it by opening up markets and allowing competition to ultimately sort this out. Or we're going to continue to subsidize the systems that they have around the rest of the world. And as a public policy maker, and as much as we spend on health care, again I say we should not be required to subsidize the starving Swiss.

Glassman: Let me ask this question of Dr. Friedman and then we'll get to these… Is there something about being the world's leader in innovation in the richest country in the world that essentially means that there will be free riding by other countries? For example, Germany used to have the most thriving drug industry in the world. They invented Bayer aspirin. Now a lot of people believe, largely as a result of their health care system, they're pretty much out of it. And 85% of new drugs are developed in the United States. But the question is is free riding, for example in defense, where we provide almost all the defense in the world, in health care, is that kind of a natural component that we shouldn't necessarily worry about? We can whine about it, but there's not much we can do about it?

Friedman: Well, free trade is a form of free riding for everybody.

Glassman: And that's generally good, right?

Friedman: I think so. I think everybody benefits from everybody else benefiting.

Glassman: And if we didn't have free trade for example in pharmaceuticals, then not only--

Friedman: We don't have free trade in pharmaceuticals. Remember, we don't really have free trade in medicine because of the patents. Patents are a form of monopoly which essentially are an area in which we believe we cannot have, that if we have free trade in patented things, in items and inventions, the Constitution provides for patents as a way of encouraging invention. Now, that system is one on which there's a lot of free trading, but if the system itself is really a departure from a free market.

Glassman: Okay. We're going to take questions from both people who are not here and people who are here. So here's one from people who are here. Why not allow importation of drugs from Mexico? They're even cheaper than in Canada. Congressman?

Gutknecht: Well, Mexico does not have the same FDA-type system that we have in the United States, and incidentally some people asked me, well, why did you include the 25 countries in your bill? Well, I didn't pull them out of thin air. Those are the 25 countries that the FDA told us have similar regimens to theirs in terms of protecting public health. Mexico is a bit of an outlier in terms of the regimen that they impose. And so Mexico is not included. Having said that, let me say this: Millions of Americans are buying their drugs from Mexico today, and we keep incredibly good records at the CDC and the FDA of how many people are actually injured by taking drugs from other countries.

Now, we know, for example just recently three people died and over 500 were made seriously ill by eating green onions at a Mexican restaurant in Pittsburgh that came from Mexico. Over 500 were ill and three died. We know how many people have died from taking prescription drugs from other countries in the United States. It's a nice, round number, it's easy to remember, it's zero. And so the whole idea about safety, which is the first argument that the pharmaceutical industry threw up at us simply is bogus, because it's not true. The drugs in Canada and Germany and Switzerland and the 25 countries are every bit as safe as the drugs are here in the United States. And the truth of the matter if we have more problems with counterfeiting in the United States than we do drugs being imported into the United States.

Counterfeiting happens, and if you don't know this, talk to a counterfeiter. They don't counterfeit one-dollar bills. They counterfeit the more expensive bills, the 20s, 50s and more importantly the $100 bills. Part of the reason you have counterfeiting is because prices are so high in the United States. When prices level, if people

could buy their Cumetin for $21 instead of $89 you would see less counterfeiting than we see today.

Glassman: Okay, so we have an editorial comment. You said that drug companies say that safety is the issue. It's actually the chairman of the Food and Drug Administration who says that it's an important issue.

Gutknecht: Max nix.

Glassman: What's that mean?

Gutknecht: Matters not.

Glassman: I actually knew that, but… [laughter] We have a live question from somewhere. Go ahead. [pause]

Glassman: This comes from John [unintelligible] of Bloomberg.

John: Can you hear me?

Glassman: Go ahead. Go ahead and ask the question. Oh well, all right. Maybe we're—

Glassman: Too innovative.

Glassman: Too innovative, yeah, we're way too innovative here. Okay, well, let me move on. Re-importation may not be the answer, but why must the United States consumer subsidize artificially low prices overseas? Pharmaceutical companies could still earn significant profits by charging less to US consumers and not allowing foreign governments to carry prices below the United States. So I guess the question here is what can pharmaceutical companies do perhaps to force foreign governments to pay higher prices so that Americans can pay lower prices? I guess that really raises two questions: What can they do, and will it really mean that Americans will pay lower if foreign people pay higher? You want to answer the question, Sally about what can pharmaceutical companies do—

Pipes: You go ahead.

Glassman: Okay, Dr. Friedman?

Friedman: First of all, the pharmaceutical companies are not subsidizing foreign countries by charging lower prices there. They're increasing their own profits, they are doing so for commercial reasons. And the issue is are they making a mistake? If they were really subsidizing foreign individuals, they would charge a higher price. They're not charging below cost, they're charging above marginal cost, but below average cost. That's the only way in which they can get enough money to subsidize and finance their research.

Glassman: The other issue, though that this question raises is is there a way that drug companies or someone else, Sally could put pressure on, let's say the government of Canada to perhaps raise some of these drug prices? For example, some of the drug companies are in fact withholding or cutting back on the amount of drugs that they're selling into Canada right now.

Pipes: We do know that in the year 2000, the sales of prescription drugs coming from Canada back into the US was about $50 million. In the year 2003 that number had jumped to $800 million. We've gone from 10 to 20 internet pharmacies in the year 2000 to about 140 today. And it's interesting that the Canadian Internet Pharmacy Organization that, you know, is in charge of all these internet pharmacy companies is really very much against, they've come out against re-importation of Canadian drugs back into the US because they're very concerned about pharmaceutical companies in the US withholding drugs that they're selling into Canada.

And we have see recently that companies such as Pfizer, Lilly, Glaxo, Astrozenica are cutting their exports to Canada based on historical levels. So in effect, I mean Canadians could be harmed if these internet pharmacies see that they can make more of a profit by shipping into the United States, and therefore these drugs won't be available for Canadians. So I think that's a very key point.

Glassman: Congressman, isn't that a reasonable reaction for a drug company, that if they're worried about drugs coming back into the United States, especially from a market that's so small, Canada's about 5% the size of the US drug market, that they would simply say, "Well, we're not going to sell any drugs to the Canadians?"

Gutknecht: Well, I think if you manipulate supply to hurt consumers both here and in Canada, both we and the Canadians have antitrust laws which ought to be dusted off, and I suspect they will be. I think that is unconscionable, in order to protect their profit margins. And if I could go back, and I'm sorry—

Glassman: I don't think it's an antitrust violation to say, "Well, we just don't want to sell drugs to you," because as Dr. Friedman said, you would be violating your contractual obligation to us not to sell them back into the United States. It's not an antitrust violation.

Gutknecht: I would agree with this to this extent. They have the right to say, "We're not going to do business under those terms and conditions," but back to your question that you asked Dr. Friedman, what can the pharmaceutical companies do? As I mentioned, in Germany, the United Kingdom and the Netherlands, they could simply say to those consumers, "You're going to have pay larger co-pays." But so far they have not been willing to do that. And as I say, at the end of the day if they're willing to do business under those terms and conditions in those industrialized countries, we should not protect them from the consequences of those decisions.

Glassman: Question for Dr. McCanne. This is from the floor. How do we deal with the average American consumer's expectation to want the latest and greatest drug, but not have to pay for it?

McCanne: Well, we need to revise the way we pay for health care. Our model is to place the health care system under a global budget and index that to some reasonable means of inflation. We're paying far more on health care than any other nation, and we can afford comprehensive health care for absolutely everyone. Within that global budget, you allow considerable freedom between the patient and his or her professional advisory in the system in how you obtain that care. And as far as affordability, you allocate resources through control of capital expenditures and through budgeting of each of the sectors of health care.

So it becomes less of an issue that the patient wants the latest thing, that if it's beneficial, it will be available, assuming it's not a $10 million test.

Glassman: This is kind of the ultimate question, though, isn't it? It may be phrased very simply, but I think everyone on this panel would agree that a lot of very important life-saving drugs have been developed over the past few years, including many drugs, let's say ulcer drugs, it's not my specialty, but ulcer drugs where, before they were developed I think in the late 1970s you had to have an operation. And now there are very few operations for ulcers. So people want and expect these drugs. And actually, despite the fact that a lot of people feel that they cost a lot of money, the system seems to have worked pretty well.

Maybe I should ask Sally this, and if you want to comment on what Dr. McCanne said: What would be the result of disrupting the system? Do we run some large risks?

Pipes: It's interesting. I'm going to talk a bit about national health because I grew up under a national health program in Canada. But even 12 years ago my former boss needed to have some surgery, lithotripsy, but there was only one hospital in Vancouver, a city of almost two million that offered lithotripsy, so he had to undergo surgery. So we have seen many cases in Canada where they don't have the latest equipment or the latest drugs. And we're actually saving a lot of money by drugs, as Jim said, with ulcers, for schizophrenia. Someone that was spending $73,000 a year in hospital costs for schizophrenia now may be paying $5,000 in special drugs. But it's a lot less than $73,000.

So drugs, Frank Lichtenberg at Columbia said that for every one dollar in new pharmaceutical cost, we're saving about $7.17 in keeping people out of hospitals. So there is a lot of savings because of the wonderful innovative drugs. I would like to respond to Dr. McCanne about global budgets and national health care, because Hillary Clinton had a global budget program for health care when they were first in office. And it went down to defeat. But having grown up under government health care, I don't think many people in the United States realize what it means when the government controls your health care dollars. For example, in Canada you have, because the government determines they can't afford to spend more money on health care, they limit that amount of care.

So the average wait in Canada, from seeing a general practitioner to receiving treatment today is about 18 weeks. And it used to be in 1993 that was nine weeks. So people are paying for this global budget through rationed care, where care is not available, for queuing for care, and for lack of technological equipment. Canada's ranks 20th out of 30 OECD countries in terms of the number of MRIs per million they have. They rank 22nd out of 30 in the number of CT scans. So I think Americans really need to think about whether they want the government determining their health care. And as PJ O'Rourke said, "If you think health care's expensive now, wait until it's free." Because people, when it's free, the government in Canada never realized how many people would increase their demand for health care, thinking that it was free.

McCanne: Jim, may I respond to that?

Glassman: Yeah.

McCanne: The terrible rationing word was just spoken in this room. And I think it's very important to realize that the United States has the worst rationing in the world of health care, but we ration by means of ability to pay, which is unique of all nations. Rationing, if it means better utilization of your resources is actually a good thing. The OECD published a study in July of 12 different nations, and they studied the delays in elective

surgery, because that represents very well the process of rationing. They demonstrated that you can control the queue, which is the rationing by controlling capacity, which is the most expensive method of controlling services, but it's the most effective method. And the United States is way ahead of that because we have far more resources than we need to establish proper capacity in our system.

But right now capacity is determined by the market. So in Boca Raton you have every specialist and every technological advance in that area. You have 30% increase in services over what they need with no demonstrable improvement in their health care outcomes. And in other areas you have inadequate capacity in the system. So using our resources more wisely through an integrated system of funding health care is what we need to do to improve the capacity, and then we'll all end up with the best system in the world, which we do not have right now.

Glassman: Okay. I think we're going to try our question from somewhere in the ether.

Glassman: Our first question comes from Rick [Cutsilla] from [unintelligible].

Glassman: Okay.

Rick: This is basically geared toward Mr. Friedman. Understanding that we talked a lot here today about whether or not the US should be regulating or these other countries ought to be regulating the price. But I wonder if more shouldn't be talked about regarding negotiating the price. It strikes me that in the United States the issue is that we're not negotiating the price. The new Medicare law specifically would preclude it.

Glassman: Okay. Did you hear the question, Dr. Friedman?

Pipes: I think it was to Congressman Gutknecht about the new Medicare bill restricting or negotiating prices for pharmaceutical—

Gutknecht: Well, I think the question was to Dr. Friedman as to whether or not we shouldn't allow at least negotiation by the federal government, if the federal government especially now is going to become a much larger buyer. Let me just say that I voted against the prescription drug bill, okay? [applause] And I voted against it for a variety of reasons, one of which was mentioned by the caller, and that is here we're going to be spending, and the estimates originally were $400 billion. We are now told they have a new estimate which will be significantly higher than $400 billion. Again, I'm not an expert but I talk to people that are smarter than I am.

Over the next ten years it's estimated that seniors alone will spend $1.8 trillion on prescription drugs and I think that number will actually go up. So I think that the cost of this prescription drug bill is going to be much much higher. And it seems to me to be outrageous that if we're going to spend that much in terms of taxpayers' dollars, somewhere between $400 billion and $1.8 trillion on behalf of the taxpayers for prescription drugs, it does strike me as outrageous that we're not going to allow the Department of Health and Human Services to negotiate those prices. Essentially we're allowing Americans to be held captive, we're putting them up against the wall, and now the taxpayers are going to pay the bill. And to go back to something Ms. [Ride] said, if you think drugs are expensive today, just wait until the government pays for them.

So I think things are going to get worse unless we modify that law significantly.

Glassman: Dr. Friedman, did you want to comment on the issue of the government doing more negotiating on prices for drugs?

Friedman: Well, I approve of the congressman having voted against the Medicare bill that passed, I thought that was a bad bill, too, except for its one redeeming feature, which was a provision of health savings account. But of course, if the government is buying, it ought to be free to negotiate, I have no quarrel with that. I'm not trying to protect the pharmaceutical companies, they're plenty good at protecting themselves.

Glassman: I'd like to ask you a general question. In your article in the Public Interest in 2001, it was a very comprehensive article on how we got here, what's wrong with the health care system in the United States, as well as in other countries. But I don't think you talked at all about where drugs fit into this system.

Friedman: No, you're quite right, that's a defect in that article.

Glassman: But is it because to some extent the pharmaceutical part of the health care system is the most free market part that we have?

Friedman: But it isn't, because of the Food and Drug Administration it's nothing like a free market. On the drug side, what seems to me to be the most serious situation is the extent to which the Food and Drug Administration makes it extremely expensive to produce a drug, and you can understand why. The FDA is required by law to certify the safety and the effectiveness of new drugs that are offered for sale on the market. Now, you're an employee of the FDA. If you turn down a drug which might've saved millions of lives,

nobody's going to know about those millions of lives, nothing's going to happen to you. If you on the other hand approve a drug which turns out to have bad effects, the classic case is one of Salidimide, you're going to be the subject of reproach, your job's going to be lost, etc.

Your whole incentive is to be ultra-careful, to be sure that you never make a mistake in approving a drug that turns out bad. And it doesn't matter how many mistakes you make in not approving a drug that turns out to be good. So the net effect of the FDA is to introduce a bias against experimentation and innovation and development. And that's what's raised the cost of introducing new drugs so high. And that's where all the problem starts. [applause] In my opinion, the one big development you could make would be to go back to what the situation was before the so-called Tea-Falver Amendment, to have the FDA certify safety, which itself raises difficulties. But not efficacy.

And let the market itself work in determining efficacy. And that would change the situation altogether. It would lead to a much larger number of small pharmaceutical companies, it would lead to much more innovation and development and to much lower prices for pharmaceutical drugs.

Glassman: Congressman, do you agree with that?

Gutknecht: I absolutely agree. In fact, I would expand on that. It is the Food and Drug Administration, and yet they have one standard for drugs and they have almost no standard for food. Over the last three years over 25,000 Americans have become seriously ill from eating strawberries from Mexico. And what has the FDA done about it? Almost nothing. More people have died from eating green onions from Mexico than taking prescription drugs from Mexico. And yet what does the Food and Drug Administration do about it? They've created a wall that is almost, at least from their perspective impenetrable as it relates to drugs, and yet food comes into this country every day. I go back to that pork belly example.

You are far more likely to become seriously ill or die from eating meat products from other countries than you are from taking prescription drugs from other countries. And yet they continue to wave the bloody flag of safety, and it's just outrageous. And the doctor is correct that if we allowed a system that was similar to the previous regimen, we would have more drugs coming on the market at more affordable prices, and frankly at the end of the day I think Americans would be every bit as safe.

Glassman: And in fact, that might solve your problem.

Gutknecht: Well, it wouldn't completely solve our problem, but it would solve his problem. [laughter]

McCanne: I'd like to say something in defense of the FDA. As a practicing physician, I always appreciated the fact that the FDA demanded enough information from the pharmaceutical firms to show that their products were effective and relatively safe, or at least if there were problems with them, we knew what the problems were. And that's an extremely important government function that we need to protect and preserve. During the Reagan administration there was some relaxation of these standards, and in fact we saw a slew of drugs that were marketed, killed people and pulled back off the market. And I think we need to continue to support a strong FDA.

Glassman: But I think Dr. Friedman was talking about efficacy rather than safety. I don't think anyone here says the FDA shouldn't guarantee safety, although Dr. Friedman has some worries about that. But we're talking about efficacy. Doesn't the word get around among physicians, aren't papers published if a drug is not efficient? In other words, why does the government have to come in and give its stamp of approval?

McCanne: I think I saw the other day that there are about 500,000 articles published each year in the medical literature. And there is no way a practicing physician can do their own comprehensive research. And it's very valuable to have an agency that does do that research for us to show that these agents are efficacious.

Gutknecht: Can I just say this, though? And pardon me for interrupting here, but do understand this: No matter how much we study a drug, no matter how much we test it, we know that in a universe of people, certain people are going to have an adverse reaction, and let me defend the pharmaceutical industry on this point. I think this is also driving our cost. If they have an adverse reaction to a new drug here in the United States, the drug companies tell us, and I believe it's correct that it can cost them $100 million in terms of liability. If they have an adverse reaction in Europe, it will be about $100,000. Now, at some point we have to deal with this unbelievably expensive tort liability system we have in the United States. So in that case… [applause]

Glassman: I think we have another question from somewhere.

Glassman: The next question comes from Michael Johnson of the Drugstore News.

Johnson: Good afternoon. I was…

Glassman: Anyone like to answer that question? [laughter]

Johnson: --to the economic impact on pharmacy, number one? And number two, the impact on health care taking patients out of the pharmacy and placing them into an internet dispensing area.

Glassman: So the question is I guess about costs of the role of pharmacies in the system as opposed to internet dispensaries.

Gutknecht: I have actually spent a little bit of time with pharmacists, and his concern I think is legitimate. The pharmacist plays a very important role in our health care delivery system, and this is why, it may sound bizarre, I'm not in favor of people buying their drugs purely on the internet. Now, I will have to say to the pharmacist, though, once you've been on a drug for a year, and if it's a maintenance drug that you're going to stay on perhaps for the rest of your life, you pretty well know a lot about the drug, when to take it, whether to take it with food, all the other things. Where the pharmacist can add value begins to diminish the longer you're on that drug.

But my vision is not that people will buy their drugs on the internet or from Germany or wherever. My vision is that that pharmacist will have the same power that they have in Europe. Most of the pharmacists have the power. If they can buy a particular drug cheaper from a pharmaceutical supply house in Sweden or Germany or Denmark or England, this is what's called parallel trading. And ultimately that is my vision, so that pharmacists would have the ability to go online and say, "Look, I can order that drug from a pharmaceutical supply house in Munich for 40% less." And once you do that, that's when you get the market power working to the advantage of American consumers, and frankly to the advantage of American pharmacists as well.

Glassman: I just want to go back to some… I'd love to hear your comment on something that Dr. Friedman said earlier. He pointed out that there are patents to protect the intellectual property rights of the companies that develop them. And then the companies enter into contracts when they sell abroad. And the contract itself says, "You can't resell that product into the United States." Those are parties that are freely entering into those kinds of contracts. Do you think that such contracts should be illegal? Aren't they freely entered into by both parties? What's wrong with that?

Gutknecht: Well, first of all I'm not certain that that's true. I don't think that they enter into those contracts with those suppliers because—

Glassman: Well, certainly in Canada—

Gutknecht: Parallel trading happens every day in Europe, and Europeans are not intrinsically any smarter than we are. And more importantly there is no empirical evidence that Europeans are at any health risk because their pharmacist may be getting his supply of drugs from a different country. And so I don't think there is that contract, I don't think it's an implied contract. Parallel trading happens all over the rest of the industrialized world. The United States is the only country where we literally hold American consumers captive.

Friedman: Should the pharmaceutical companies be prohibited from entering into such a contract?

Glassman: That's for you.

Friedman: That's for you. [laughter] Should Pfizer be free to enter into a contract with Canada saying, "We'll sell you a certain amount of goods provided you agree not to resell in the United States?"

Gutknecht: I would have to think about that, Dr. Friedman. I guess my first reaction's no, they should not be prohibited, but I think it would be foolish to think that pharmaceutical supply houses in Munich would ever agree to that kind of a contract. I mean, they currently trade all around the world, and for them to literally sign an agreement that says, "We would sell to anybody else in the world except United States pharmacists," I'm not sure that they would sign that contract in the first place, and secondly I'm not sure that contract would be enforceable in any kind of a world court.

Pipes: In Canada, when Pfizer's sell the drugs into Canada, the Canadian government has determined that it's not their responsibility to control them shipping back in. So they say the responsibility is on the side of the US courts. So Canada doesn't make a decision on that. The other point I wanted to make was that the Canadian Medical Protective Association, which is the insurer for malpractice in Canada has determined as of January 1st this year that they will not cover any Canadian doctors who sign prescription drugs, which are then imported back into the United States, and if a patient becomes ill, they will not defend those doctors in the American court system.

They also are looking at whether they're going to defend these doctors if they're sued in the Canadian court system. So I think this is going to be a major issue, because as everyone knows, America is such a litigious country, and malpractice is such a booming business, which does need to be reformed.

Glassman: Let me just add, this is the last question from the floor, I'm going to ask it to Dr. McCanne first. I'd like to hear Congressman Gutknecht's comments, and then we'll

end with Dr. Friedman's comments. The question is this: Top-down, command and control stifles innovation writes someone sitting in front of me. I think that's a pretty good proposition. How does Dr. McCanne expect innovation to occur?

McCanne: Well, just not top-down control, but funding. You know, price controls and budgeting and so forth. And that really is an important issue in innovation. But if we look at the history in technological innovation, probably two of the very greatest advances in the last half century have been MRI scans and CT scans. Each of those appropriately received the Nobel Prize for those developments. Where were they developed? Well, the Nobel Prize was shared with a British scientist. England has amongst the lowest rate of funding of their health care system, but that did not stop the technological innovation that occurred in the CT scanning and MRIs, and some of the other research that has taken place.

Glassman: Let me just refine this question a little bit and hear from the congressman, and then finally from Dr. Friedman. Innovation is kind of what I spend a lot of my time thinking about. And it's quite clear that our system, which is relatively free in these areas despite problems with the FDA, does promote innovation in drugs. I mean I think that would be very hard to argue against. Disrupting that system in the way that you propose, many people think would stifle that kind of innovation. Where is this innovation going to come from if it's not from drug companies wanting to make decent profits on developing new drugs?

McCanne: May I finish on that a little bit?

Glassman: Just really briefly because we're going to run out of time.

McCanne: Right. There's no way the drug industry is going to walk away from $1.6 trillion, period.

Gutknecht: Well, first of all I want to pierce this myth that they don't do any research in Europe with the system that they have. If you look at the major pharmaceutical companies, Glaxo is a British company. Bayer, as you mentioned, we call it Bayer, is a German company. Incidentally, they developed a very effective antibiotic which we in Washington got our hands on, millions of capsules called Cipro, and that was developed under the German system. Roenpalanc is a European company, Astrozenica is a European company. Roche Labs is a Swiss company. So the idea that no research goes on in Europe is really a myth.

And so the idea that somehow if we open up markets and allow more competition that research will somehow stop I think is really a myth and we need to discard

it. Let me just share with you one other thing, too. And that is I think there are people old enough in this room that can remember back in the '40s and '50s when virtually every hospital in the United States had at least six iron lungs. And along came a guy by the name of Jonas Salk, and Jonas Salk with the help of the March of Dimes and almost no help from the federal government, this was done almost completely with private resources, developed what may well have been one of the greatest discoveries of the last century, it was called the Salk Vaccine.

Here's the interesting thing about Jonas Salk and the development of that vaccine: He didn't patent it, he gave it away. And he was asked later by Edward R. Murrow on a CBS television program why he didn't patent the Salk Vaccine. Because ultimately it was worth billions of dollars, it saved millions and millions of lives. And the answer he gave I think was very instructive. He said, "Because you can't patent the sun." I represent Mayo Clinic and I'm proud of the research we do at Mayo Clinic, and for many years they didn't patent anything that they developed there, either. In fact, the drug cortisone, which became a multi-billion dollar drug was developed by researchers at Mayo Clinic. They gave it away.

The idea that you have to have billions of dollars in return, and especially when much of the research is essentially funded by the taxpayers. We're going to spend this year, and I'm proud of this number, we're going to spend $27 billion of your dollars on basic research from the federal government this year. And much of that will be given away to the pharmaceutical industry. And so this whole notion that unless we protect these exorbitant prices that Americans are forced to pay, that research won't be done, I think that's a myth. And I think there's plenty of history to prove that.

Glassman: Dr. Friedman?

Friedman: Of course research will be done. I think it is an exaggeration to say that the only source of research is the existence of patents. It isn't. There's been enormous progress in medical science over the last 100 years, most of it in ways that have very little or nothing to do with the patent system. They're through universities, they're through non-profit organizations, through government [things], so that the issue is not will there be any innovation or not? The issue goes back to the question of do you want to grant patents? And if you want to grant patents, what contracts which the patent owner makes are enforceable in the courts? That it seems to me is a straight-forward issue.

Do you want to make illegal price discrimination? I think we do not, we have it all over. Sally cited the great example of the airplanes, the airfare in which you have first-class fares, second-class fares. Sometimes there's very little difference between

the services rendered, but there's a big difference in the prices charged. So I'm not arguing that this is the be all or end all of innovation, it isn't. But it is true that it costs a great deal of money, thanks to FDA provisions to bring a new drug to market, and that you have to face the question of how is that going to be financed? And is it going to be financed through patents or is it going to be financed through government subsidy? That's I think the issue at bottom, it's not an easy issue. Don't misunderstand me. As I say, I personally had very mixed feelings to begin with about this issue.

My initial reaction was to say, "Of course we want to let the market completely work, and instead of having the government defend the patent, let the patent owner defend it. Leave it up to Pfizer and to the other pharmaceutical companies to enforce price discrimination." But the more you look at it, the more you see that's inconsistent. We will defend the patent at home, we will defend the patent against the importation of counterfeits, and the question is should we also enforce the contracts which prevent re-importation?

Glassman: Thank you very much, I just want to, just as a point of information, Congressman Gutknecht talked about drug companies that are not based in the United States, though more and more are doing research in the United States. The latest figures I've seen are that 80% of new drugs are developed by US-based companies. Be he's absolutely right, there are companies outside the United States. But I wonder what would happen to these companies if they were not able to sell drugs at market prices in the United States, which they all do. This has been a fascinating discussion, I thank everyone, those who traveled long distances, Dr. Friedman, Sally Pipes and the Pacific Research Institute for putting this together. Thank you, congressman, thank you Dr. McCanne, thank you audience.

Glassman: Thank you. [applause]

[End]