The Solution to Drug Prices

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We're paying too much for prescription drugs. The price for cancer drugs like Yervoy, Opdivo and Keytruda routinely exceeds $120,000 a year.
Some other specialty drugs have even higher prices. Cerezyme for Gaucher disease costs about $300,000 per year for life. Kalydeco for cystic fibrosis also costs about $300,000 per year.

Despite representing about 1 percent of prescriptions in 2014, these types of high-cost drugs accounted for some 32 percent of all spending on pharmaceuticals.

Polls show that Americans are fed up with high drug costs. A commonly proposed solution has been to let the federal government, through Medicare, negotiate with drug companies. Currently, while Medicare tells hospitals and doctors what it will pay for services, by law it cannot negotiate with companies for lower drug prices. Some independent estimates suggest that negotiated drug prices could save the federal government $15 billion or more per year.
But this approach will not solve the problem of stratospheric drug prices, for several reasons. For many diseases, there exist only a couple of effective drugs, with little price competition. Also, Medicare would have little negotiating leverage since, unlike private insurers, it cannot maintain an approved drug list and exclude overly expensive drugs from coverage.

The bigger problem, though, is that Medicare negotiations would do nothing to contain drug prices for the 170 million Americans who have private health insurance, through their employer, the exchanges, or by self-purchase. Having the federal government negotiate lower prices for Medicare would most likely drive up prices on the private side as drug companies tried to recoup their "lost" profits.
Almost all developed countries — including those run by very conservative governments — have an effective solution for drug prices, which is why these countries often pay less than half of what people in the United States pay for drugs. For instance, Australia's more than 60-year-old Pharmaceutical Benefits Scheme has been the single purchaser of drugs for the country, making drugs available at fixed prices that are now listed online.

If the United States were to consider such an approach, drug companies would immediately raise two objections: the high risks associated with drug development and, related, the high cost of research and development. But both of these arguments are fatuous. It is true that a vast majority of drugs fail. **On average, only one in every 5,000 compounds that drug companies discover and put through preclinical testing becomes an approved drug. Of the drugs started in clinical trials on humans, only 10 percent secure F.D.A. approval.**
Regardless of the risks, many drug companies are making huge profits. Gilead, maker of Sovaldi, has profits of around 50 percent. Biogen, Amgen and other biotech firms have profits of around 30 percent. Merck and Pfizer are seeing profits of 18 percent or more. Even if profits were cut by a third or a half, there would be sufficient incentive to assume the risks of drug development.

What should be done? The United States government has created myriad special pricing arrangements that pervert incentives. For instance, Medicaid generally gets the lowest prices in the market. This discourages drug companies from experimenting with other payers on lower price arrangements, knowing that they will most likely have to give the same deal to Medicaid. Similarly, through the Orphan Drug Act of 1983 the United States created many incentives for developing drugs for orphan diseases — those with fewer than 200,000 patients nationwide. Through special tax credits and better deals on marketing exclusivity, the federal government is encouraging the companies to benefit thousands instead of millions. The result has been the development of more than 400 drugs and biologics. While it is important to find effective treatments for rare diseases, it is more important to target serious, common diseases such as stroke and antibiotic-resistant infections.
Also, as outrageous as they are, prices are not the real issue. Value is. What really frustrates people are expensive drugs that do not provide a cure. For instance, Opdivo adds an average of 3.2 months of life to lung cancer patients and costs $150,000 per year for treatment.

Conversely, other drugs are super-expensive but are worth it. There was an outcry over paying $1,000 per pill for Sovaldi. But it helps cure hepatitis C and has shown to be cost-effective.
While the Australian system of price controls is one approach, another possibility is the Swiss health system, which is frequently applauded by conservative commentators. The Swiss government includes only those drugs that are effective and cost-effective on its approved drug list. It then establishes a maximum allowable price for the drug, but up to that point, companies can decide what to charge. We could cap the price based on objective, quantitative measures of value. Private payers would continue to negotiate with drug companies over prices as they do now, but there would be a ceiling to prevent prices from becoming unsustainable

Everyone, including drug company executives, believes that high prices cannot continue. Indeed, that is one reason that companies are trying to maximize profits while they can. We must come up with a comprehensive solution now.

Infos

Les Sortilèges du Cerveau: l'Origine présumée de l'Hystérie au XIX^{e} siècle

Dans l'Europe puritaine du XIX^{e} siècle, l'hystérie était une affaire de passion. On la considérait comme un fléau social dont on cherchait l'origine dans les mœurs plus que dans la médecine. Au cours de la Révolution française, on voit naître l'aliénisme à Paris avec Pinel et Esquirol. Au cours de l'effort de classification des maladies qui caractérisent cette période, on cherche la place de l'hystérie dans l'ensemble des maladies mentales et en particulier en regard de l'épilepsie et de l'hypocondrie. Pinel les sépare plaçant l'hypocondrie dans les vésanies et l'hystérie dans celui des « spasmes ». Elles font toutes deux partie des « névroses » (« maladie des nerfs »), un mot inventé par l'Anglais William Cullen.
Le siège de l'hystérie restera une question débattue tout au long du siècle. Le Breton Jean-Baptiste Louyer-Villermay, chirurgien à l'hôpital de Rennes, défend son siège dans l'utérus, les troubles fonctionnels étant liés à l'innervation de cet organe. Son origine est à chercher dans la continence volontaire ou forcée. Pour d'autres, comme Jean-Louis Brachet, médecin de l'Hôtel-Dieu de Lyon, il s'agit d'une infection spasmodique du cerveau, tout comme pour un élève d'Esquirol, Étienne Georget. La théorie utérine est également rejetée par Paul Briquet qui positionne l'hystérie en névrose de l'encéphale. Travaillant à l'hôpital de la Charité, il collige 430 observations d'hystériques en dix ans, dont 7 cas d'hystérie masculine. Pour lui cette maladie permet une transition entre le normal et le pathologique par le canal des « passions ».