What Drug Companies Aren't Telling YOU

In the past two years, the U.S. economy struggled under a recession, with unemployment rising to its highest level since 1995. Record-setting stock plummets burst Wall Street's bubble. Working families are seeing their health benefits and retirement savings wither.

But one U.S. sector continues to thrive: the massive pharmaceutical industry.

Documenting the sometimes obscure routes taken by the drug industry in its quest for ever-greater profits, *The Big Fix: How the Pharmaceutical Industry Rips Off American Consumers*, a new book by Katharine Greider, published by Public Affairs, reveals how big pharma maintains a stranglehold on the health and pocketbooks of working families. Greider's meticulous research explores the industry's profit-over-research priorities, its complex and unregulated pricing practices, pervasive advertising and marketing strategies, excessive influence on the doctors who write prescriptions and cozy relationships with the nation's lawmakers.

Drug costs: hard to swallow

The current economic downturn—the worst since the 1980s—disproportionately savaged millions of the nation's seniors because they tend to use more medications and depend on fixed incomes that cannot keep up with spiraling costs, Greider writes. The elderly on fixed incomes struggle to pay for life-saving prescription drugs that have risen in price by more than 15 percent a year—five times the rate of inflation for the past several years, according to *The Big Fix*. One result: 29 percent of Americans failed to fill a prescription in 2000 because they could not afford to, says Greider.

While families struggle to pay for medicine and deal with an increasingly bleak economic picture, drug makers prosper. In 2001, as the economy tumbled and corporate profits sank for the average Fortune 500 company, drug companies on the top 500 list saw their profits soar by 33 percent from the previous year, Greider reports.

The nine largest pharma giants raked in $30.6 billion in 2001 profits. During the past decade, drug firms' profits represented an 18.5 percent return on revenue or 5.6 times the median return (3.3 percent) of Fortune 500 companies. As the economy soured further in 2002, many drug companies continued to grow and thrive.

Working families and seniors may worry about skyrocketing prescription drug costs, but big pharma executives are not likely to be choosing between blood pressure medicine and buying groceries: The five most highly paid drug company executives pocketed more than $183 million in compensation in 2001, with the top 25 pharmaceutical execs averaging nearly $6 million in annual compensation in 2000. That compensation does not count stock options, which can add millions of dollars to a CEO's income. In 2000, Greider reports, the chairman and CEO of Bristol-Myers Squibb held unexercised options valued at $227.9 million. (For the latest information on executive pay in the pharmaceutical and other industries, visit the AFL-CIO's Executive PayWatch.)

A prescription for profiteering

The drug industry's gargantuan profits result in large part from big pharma's business practices that industry critics say border on the unethical—practices that have helped boost the number of prescriptions written from 1.9 billion in 1992 to more than 3 billion 10 years later, while jacking up the price of an average name-brand prescription from $27 to $65, according to Greider.

Traveling to Canada for affordable medication

Melva McCuddy calls it her "big trifecta": heart disease, cancer and diabetes. She takes tamoxifen for the cancer, Glucophage® XR for the diabetes, Norvasc® for blood pressure and

several other medicines for the heart disease and other ailments. She pays for all that from a modest pension from her late husband's job and her Social Security.

If forced to buy those medicines at her local pharmacy, McCuddy says, "that would nudge about $700 a month."

She has two ways to help keep her costs down. First, she makes regular bus trips to Canada, an 11-hour ride from her Springfield home in southwestern Ohio, to take advantage of the lower prices north of the border.

"For five years, I have been taking tamoxifen. I shudder to think where I'd be if I had to pay full price for that all these years." Her three-months supply would have cost $287.16 here. It costs $38.25 in Canada, she says.

But McCuddy, whose story is among those featured in The Big Fix, worries that the pharmaceutical industry will use its muscle to put an end to the Canadian alternative.

"They're trying to get the FDA [Food and Drug Administration] to do it. Saying they're not the same drugs as here, they're adulterated, out of date. They say they want to protect our health. That's an out-and-out lie. It's the same exact medicine. Heck, a lot of it's made right here in the States. They just want to keep their profits up," she says.

Protecting drug patents: Patents allow drug makers the exclusive manufacturing rights for 20 years or more before competitors can market generic versions. But generics not only can save consumers as much as two-thirds of the original drug's cost—they cut heavily into the sales and profits of name-brand drugs. When the hugely popular antidepressant Prozac® lost its patent protection in 2001 and the generic version hit the market, Prozac sales plummeted by 80 percent. In turn, Prozac's maker Eli Lilly and Co. saw its overall sales drop 16 percent and its stock value fall by 25 percent the first year without Prozac exclusivity.

To protect their patents and profits, the drug industry "evergreens" or reformulates a product just before it goes off patent by claiming some new formulation such as a time-release version or by combining it with another existing drug, marketing it for another illness or even claiming a patent on an inactive ingredient. A minor change extends a patent and a product's profits for at least another three years. Bristol-Myers Squibb Co. tweaked its popular diabetes drug Glucophage® by making it time released and renamed it Glucophage® XR—creating a "new" drug buffered from cheaper generic competition.

Same drug, different patent: Anyone who watches television—where the majority of the drug industry's $2.5 billion a-year-and-growing advertising budget is spent—has seen commercials for AstraZeneca's acid-reflux drug Nexium®. The ad money worked: Consumers spent $458 million on Nexium, at an average cost of $117 per prescription in 2001, the first year it was introduced.

Acid-reflux sufferers could have found just as much relief in an older product that drug experts call virtually identical—Prilosec®. Ironically, Prilosec is made by the same firm that put the Nexium hype into overdrive. Is AstraZeneca cannibalizing its Prilosec profits? Not by a long shot.

Prilosec's patent was set to expire in October 2002, opening the door for other companies to jump into the market with cheaper generic versions. So by tinkering with the formula, AstraZeneca received a new patent and extra years of exclusivity to convince consumers the

new product, Nexium, is not only better than the nearly indistinguishable older drug but is also worth the extra cost.

The cost of prescriptions for two new oral diabetes drugs jumped 62 and 41 percent in 2001, and on average the costs for the new drugs are twice as much as for the effective older oral diabetes medicines.

"The increase in prescriptions—and in spending," writes Greider, "is largely attributable to the rapid market penetration of a small number of new, expensive best sellers." In 2000 and 2001, "vast outlays for only 27 drugs were responsible for about half the nation's increased drug spending."

Drug cost depends on who's buying:
While consumers pay twice as much for new diabetes drugs or $117 for a Nexium prescription, the real cost of the drugs depends on who's buying them. "It is a unique feature of the drug industry that there is no set price for its product," Greider points out.
Because they want to corner the market on popular drugs, drug makers who manufacture competitive drugs, such as Zocor®, Mevacor® or Lipitor® for cholesterol control, curry favor with volume buyers—federal agencies such as the Defense Department and the Veterans' Administration—through lower prices. Other bulk buyers, including hospitals, HMOs, insurers and pharmacy benefit managers (PBMs)—the for-profit companies that insurers and large employers hire to administer drug benefits—also get price breaks.
Uninsured, cash-paying individuals pay the most. Greider says on average the same drug that costs a cash-paying patient $100 costs the federal government $58 and costs private insurers or PBMs $70 to $95. And no one knows a drug's real wholesale price or what discounts other customers receive because the drug industry claims that such information is a trade secret—proprietary information.

Better drug deals overseas:
The drug pricing game in the United States looks even more unfair when compared with the way big pharma deals with foreign markets. On average, Italians pay 53 percent of the U.S. cost for a brand-name drug, while the French pay 55 percent, Swedes 64 percent, Germans 65 percent and Swiss and United Kingdom residents 69 percent.
"Perhaps most galling," Greider writes, "is our neighbors in Canada pay about 62 percent of what we do for the same medicines." Sixty tablets of the cholesterol drug Zocor cost $43.97 in Canada and $109.43 just across the border in Vermont. The arthritis drug Relafen® runs $60 for 100 pills in Canada and $120.27 in Vermont. It's no wonder more and more U.S. residents cross the border to fill prescriptions. In spring 2002, the Alliance for Retired Americans organized its first Rx Express bus trips to Canada, and 375 seniors saved more than half a million dollars on their prescriptions.
Unlike the United States, the governments of Canada and most other nations play a much bigger role in prescription cost control. Greider says the Canadian government buys about one-third of all drugs sold in the country to distribute to the elderly and low-income residents. In addition, Canada's Patented Medicines Prices Review Board puts a ceiling on what drug makers can charge—and enforces it.

Drug monopoly and physician influence:
Competition in the drug industry continues to vanish as mergers gobble up competitors—guaranteeing higher profits for industry giants. Since 1999, 10 big drug makers have merged to become five megamanufacturers.

Drug companies jockey to influence physicians' choices in prescribing medication. Sales representatives shower doctors with free samples and office supplies such as gowns and prescription pads covered with company logos.

Some companies offer so-called in-house educational opportunities for physicians to continue the medical training necessary to renew their medical licenses. Free dinners, paid junkets, speech slots at symposiums with accompanying monetary honoraria all can influence a physician's decision to prescribe one blood pressure medicine over another. The drug industry paid for 314,000 so-called educational events in 2000, up from 70,000 in 1993.

Conflicts of interest in drug tests:
Tightly monitored clinical trials are essential to determine safety and effectiveness before medicine hits the market. Yet today most of those tests are underwritten by the drug makers—70 percent of the funds to support U.S. clinical trials came from drug companies, according to Greider. As recently as 1991, 80 percent of the industry trial research funds were spent at academic institutions where drug makers had little or no control of the research—but today the majority of those funds are spent with for-profit contract research organizations.

"The process is rife with opportunities for drug companies to mold the message that emerges from the research," writes Greider. "Companies increasingly insist on designing studies and controlling raw data. If the results are unfavorable, drug makers are sometimes able to prevent them from coming to light."

Reining in drug costs
One way to rein in the questionable practices, pricing and other abuses of the pharmaceutical industry would be to pass tough new laws and regulations, including price controls that most other nations use to keep medicine affordable for their citizens. But Greider says the drug industry's powerful presence in Washington, D.C., makes such legislation next to impossible.

The pharmaceutical industry can count on a team of 625 lobbyists—more than the number of members in Congress—to influence legislation seeking to limit the industry's power or decrease its profits, such as new prescription drug benefit legislation for seniors or prescription drug price controls.

In the 1999-2000 election cycle "drug companies spent more money to influence politicians than did insurance companies, telephone companies, electric companies, commercial banks, oil and gas producers, automakers, tobacco companies, food processors and manufacturers—more, in short, than any other industry," Greider writes. "Most of that—about $177 million—went to hire lobbyists from 134 firms, including 21 former members of Congress. The industry also gave $20 million in campaign contributions and spent $60 million on issue ads."

As the debate over the cost of prescription drugs, the health of the nation's working families and the pharmaceutical industry's influence and practices grows more intense, it's certain drug makers will ratchet up their political efforts.

"The industry has managed to put across the self-serving notion that whatever is good for the drug business is good for the public health: tamper with us, say drug makers, and it's patients who will suffer," Greider writes. "With drugs becoming a more expensive, and indeed a more important tool in preventing and treating disease, can we afford to let this equation go unchallenged?"
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