The CEO SERIES

Business Leaders: Thought and Action

Thoughts Toward a Medicare Drug Plan

An Original Essay Written for CSAB

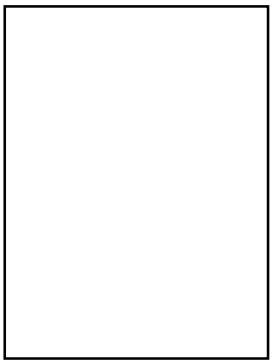
by William C. Steere, Jr.
Chairman and Chief Executive Officer
Pfizer Inc

CEO Series Issue No. 35
September 1999

Center for the Study of American Business
Washington University in St. Louis

Thoughts Toward a Medicare Drug Plan

by William C. Steere, Jr.



William C. Steere, Jr.

In August, the *New York Times* reported a story that reminded us of one of the great triumphs of this century. According to the Centers for Disease Control, death rates from cardiovascular disease in the U.S. have plummeted more than 60 percent since the 1950s. The sources of this success are hardly a mystery. They include lower smoking rates, public health campaigns, and of course, better medications for treating heart disease and high blood pressure.

We should keep successes like this in mind as we enter into a serious national debate over pharmaceutical coverage for Medicare beneficiaries. And while many points of view will be aired and differences exposed on this issue, there is one point on which consensus is emerging: the near-poor elderly in America need expanded coverage for prescription drugs. The role of prescription drugs in prolonging lives and fighting disease has made innovative medicines an indispensable component of both public and private health care.

Unfortunately, there is no consensus on precisely how to expand coverage for the elderly. So it has become the duty of the American political system to fashion a plan. In this enterprise, no one has all the answers, and in the end a compromise among conflicting approaches may yield the most workable solution. This brief document is an attempt to outline both the principles we should look for in any new plan and some alternative ways to achieve our goal.

In the coming Medicare debate, let us recognize that the research pharmaceutical industry's capacity to dis-

William C. Steere, Jr. is the chairman and chief executive officer of Pfizer Inc.

cover new medicines cannot be compromised. We are on the verge, I believe, of extraordinary breakthroughs. The notable successes achieved in cardiovascular treatment are within grasp for diseases of the central nervous system, respiratory system, digestive system, and immune system, among others. President Clinton understands the importance of a vital research industry, and in remarks introducing his Medicare Plan pledged his commitment to keeping America's pharmaceutical research the best in the world (see "The Role of the Pharmaceutical Industry" section below).

But the "how" of addressing drug coverage for those elderly who need it is every bit as important as the "why."

Under a proposal introduced by the administration, the government—through pharmaceutical benefit managers—would purchase prescription medicines for all seniors. This would make the federal government a purchaser of immense power that would inevitably flex its buying muscle by demanding deeper and deeper discounts from pharmaceutical companies. Such price controls would decrease revenues sharply and, as has happened in Europe, decrease research, reducing to a trickle the torrent of innovative medicines that we are now producing.

The "how" of addressing drug coverage for those elderly who need it is every bit as important as the "why."

In short, government-driven price controls would undermine pharmaceutical innovation.

How do we keep the short-term benefit of broader coverage and avoid the long-term catastrophe of diminished drug discovery? We should begin with an often overlooked fact: Two-thirds of all Medicare beneficiaries have some form of prescription drug coverage, with 28 percent of all beneficiaries receiving employer-sponsored drug coverage. Those with drug access provided through a former employer usually have excellent coverage that enables recipients to choose from a wide range of medicines for only a modest co-pay. Yet under the Clinton Plan, those recipients would

be herded out of their existing programs and into the same Medicare plan.

We need a more coherent plan based on firm principles—principles that would shape and inform the specific policies. Such principles are not difficult to identify:

- **Leave the choice of medication to the doctor and the patient.** It is critical that elderly Americans have access to all medicines approved by the FDA. But the choice of drugs should be a medical decision, not a political one. "Who chooses my medicine?" is a fundamental question we must put to every Medicare reform proposal.
- **Help those who need help.** Instead of spending billions of extra dollars to provide a government-funded program for people who already have excellent drug coverage, we should concentrate our efforts on providing support to those who lack coverage and desperately need it. By focusing on people truly in need, we can dramatically scale back costs in any government-funded pharmaceuticals program.
- **Promote innovation and pharmaceutical research.** Medicare drug coverage cannot come at the price of inhibiting research that creates life-prolonging medicine. Price controls, whether explicit, implicit, current, or future, invariably stifle the creative engine of the pharmaceutical research industry.

With these principles in mind, it should be possible to craft approaches that focus on people truly in need, that dramatically scale back public costs, and that reduce the potential burden on all taxpayers.

With these principles in mind, it should be possible to craft approaches that focus on people truly in need, that dramatically scale back public costs, and that reduce the potential burden on all taxpayers. There may be many other creative ways to achieve this realistic goal. Here I offer three paths to consider:

The Role of the Pharmaceutical Industry

It is the mission of the pharmaceutical research industry to discover and develop innovative, effective medicines. It is something we do very well. Death rates in the past 30 years for diseases treated with pharmaceuticals have dropped anywhere from 21 percent (hypertension) to as much as 74 percent (atherosclerosis) and 83 percent (rheumatic fever and heart disease).

Fulfilling the mission of discovery and development, however, requires immense resources. The cost of R&D per new drug approved averages more than $500 million, and the process takes about 14 years. Of all of the compounds screened in laboratories, the odds of being approved are no greater than one in 5,000.

Those few medicines that do receive approval for marketing are real workhorses, serving three important functions. First, they improve human health; many save lives. Second, those medicines make money for shareholders, employees, and the communities where we do business. But there is a third and equally important function served by our successful drug candidates. They fund future research. In recent years, virtually 100 percent of our profits have been plowed back into R&D the following year.

This dynamic of profit paying for research is the engine behind innovation. When that dynamic is interfered with through excessive government regulation, innovation falters, as it has in Europe.

Europe was once the world's greatest medical innovator. But today it lags behind the U.S. The cause is excessive government interference in the marketplace. In most European countries, the government is the largest purchaser of pharmaceuticals. Governments use their power to negotiate down the price of drugs. The end result is significantly less profit for manufacturers and, consequently, significantly less revenue available for research.

The numbers tell the tale. Between 1975 and 1994, the United States developed 45 percent of new major drugs. France produced only 3 percent; Germany, 7 percent; and the U.K., 14 percent. By the year 2002, European pharmaceutical companies will supply only five of the world's top-selling drugs.

U.S. dominance is not a function of better scientists, only better policies. The U.S. encourages R&D—and the innovation it produces—by allowing the industry a fair return on its investment.

- **Expanded insurance alternatives.** Providing drug insurance plans to Medicare beneficiaries who need one without creating an expansive and universal new Medicare program may be the most direct way of helping the elderly gain access to the medicines they need. Potential approaches: A new drug insurance product could be developed by private insurers, for example, with subsidies given to the low-income elderly. Alternatively, existing "Medigap" plans could be modified to enhance prescription drug coverage or to offer an optional drug-only insurance plan. Either of these options would require minimal changes to existing programs, target the most needy population, and, moreover, allow Medicare beneficiaries satisfied with their current arrangements to keep what they have.
- **Tax credits or tax deductions.** Another way to take advantage of the private insurance market to meet the needs of elderly would be to establish a tax credit or tax deduction program that would effectively subsidize the cost of prescription drug insurance. Here again, coverage could be significantly expanded without overturning a system that now serves many others very well. Access to medicine would be enhanced without limiting, restricting, or discouraging investment in future pharmaceutical R&D.
- **Block grants.** Block grants could provide an appropriate sum of money to create drug access programs for low-income residents in each of the 50 states. Each program would be designed to meet local needs. One key strength of this proposal is that it adheres to a sound criterion for any public policy: it puts the resources for implementation of policy nearest the people to be served. From the very practical point of what is politically achievable, block grants offer a workable compromise between different political stripes—a government-funded pharmaceutical program administered outside Washington at the state level. Block grants would work with, not against, the undeniable reality that America's health care needs are best attended to locally.

- **Expanding access, promoting research.** Any of these approaches would achieve what the administration's current proposal does not: expand drug coverage for needy seniors without restricting the choices physicians and their patients enjoy, and without damaging the R&D mission of the pharmaceutical research industry. Obviously, access to medicines and the R&D necessary to develop them are required to extend and enhance human life. To achieve both we need a plan that is fair and workable.

As I have tried to argue here, I believe there are viable Medicare drug coverage options that deserve consideration. There are also important principles against which these and other options may be judged. By pursuing proposals in a spirit of compromise and pragmatism, the United States can, at a reasonable cost, expand prescription drug coverage for our seniors and still maintain our status as the world's leader in medical discovery and innovation.

The Center for the Study of American Business is a nonprofit, nonpartisan organization, funded entirely by grants from foundations, business firms, and private citizens. It is an integral unit of Washington University. The opinions expressed herein are those of the author and do not necessarily reflect the position of the Center or Washington University. Address inquiries to: Center for the Study of American Business, Washington University, Campus Box 1027, One Brookings Dr., St. Louis, MO 63130-4899, (314) 935-5630, http://csab.wustl.edu.