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**AC(Paraphrased)**

We affirm.

Right now, drug prices are rising and the current healthcare system isn’t helping Americans. **Lockhart in 2018** finds that drug costs rose 38% from 2013 to 2015, and over 90% if hospitals identify the rising costs as a severe concern. He furthers that costs will continue to rise 14% annually.

Companies aren’t helping, as **Light in 2012** finds that out of all new drugs, only 11% were innovative, and 90% offered no clinical advantages. Worse, companies only spend 1.3% of their revenue on research in the status quo.

There are 3 reasons why voting aff reverses the current trends,

**First is Premium Spikes.**

**Mammoser in 2018** writes that a high cost of drugs leads to the cost of insurance spiking. Additionally, innovation spikes premiums. The **AARP in 2017** finds that breakthrough innovation that costs 60,000 dollars would increase premiums by over 140 dollars monthly.

The rising cost of premiums is damning, because they cause people to drop their insurance. **Baicker in 2005** writes that between 2003 and 2004, the price of premiums increased 11%, and the amount of uninsured Americans increased to 15% of the population. This puts many at risk, as **Chalabi in 2017** finds that the uninsured are 40% more likely to die, taking into account gender, age, race, and economic status.

**Second is Opioids**

Pharmaceutical companies are a major contributor to the opioid crisis. **Stojsavlevic in 2018** finds that pharma funded professionals to speak on how doctors should not fear the use of opioids, were able to get OxyContin approved without any clinical trials, and paid doctors to prescribe fentanyl. That kills thousands, as **Fox in 2018** finds that opioid prescriptions drive the epidemics, and over 63,000 died of opioid overdoses in 2016.

Price controls solve by forcing priorities into developing more beneficial drugs. **Conti in** 2016 finds that reduced prices will increase demand, and reinforce incentives for effective, affordable innovation. He furthers that current prices leads to companies throwing money at drugs with little benefit, but price controls would promote drug discovery that furthers public health. Thus, profit chasing decreases. And their isn’t a shift to marketing, since **Lexchin in 2004** finds that companies won’t shift research budgets to marketing, because of the favorable tax treatment research receives. Thus, lower prices save billions in costs.

**Third is Prescription Fills**

High cots cause Americans to ignore prescriptions, as **RUN in 2015** finds that 1 in 10 Americans don’t take their prescriptions as they can’t afford to. This is corroborate by the **PJ in 2017** who empirically find that 45 million Americans don’ take prescription drugs because of the cost and that reform on the pharma industry should target the price.

Non-adherence is deadly, as **Boylan in 2017** finds that it causes 125,000 deaths and 10% of hospitalizations annually.

Price controls solve all 3 of these issues, as the **PNHP finds in 2017** that the estimated price control in the U.S is 50%, which would save Americans 154.6 billion dollars.

We Affirm.

## Part 1: Uniqueness

#### Drug prices are rising meaning the current healthcare system isn’t helping American. Lockhart 18

Ben Lockhart [reporter, KSL], "Utah lawmaker announces bill designed to reduce drug costs," KSL, Nov 18 2018. Available at: <https://www.ksl.com/?nid=757&sid=46427627&title=utah-lawmaker-announces-bill-designed-to-reduce-drug-costs> AJ

About $328.6 billion was spent on purchasing prescription drugs in the United States in 2016, more than eight times higher than total national expenditures in 1990, according to data from the Centers for Disease Control and Prevention.**The American Hospital Association says growth in drug costs, per inpatient admission, grew 38 percent from 2013 to 2015 alone, and that more than 90 percent of hospitals across the country identify rising drug expenditure costs is "of moderate or severe concern."** Rising drug prices have also caught the ire of Intermountain Healthcare CEO Marc Harrison, who called them "outrageous" last month at the organization's annual report to the community. Intermountain is launching its own not-for-profit generic drugmaking company in 2019.**"Even as our other costs decrease through hard work, what I [Americans] can tell you is that we expect a 12 to 14 percent increase in pharma costs per year,"** Harrison in his presentation at the time.

#### And Companies Don’t Spend a lot on R&D. Light 12:

Light 12 (Donald W. Light, professor, Department of Psychiatry, University of Medicine and Dentistry of New Jersey, Joel R Lexchin professor, York University School of Health Policy and Management, “Pharmaceutical research and development: what do we get for all that money?,” 2012;344:e4348//DW

The real innovation crisis More relevant than the absolute number of new drugs brought to the market is the number that represent a therapeutic advance. Although the pharmaceutical industry and its analysts measure innovation in terms of new molecular entities as a stand-in for therapeutically superior new medicines, most have provided only minor clinical advantages over existing treatments. The preponderance of drugs without significant therapeutic gains dates all the way back to the “golden age” of innovation. Out of 218 drugs approved by the FDA from 1978 to 1989, only 34 (15.6%) were judged as important therapeutic gains.12 Covering a roughly similar time period (1974-94), the industry’s Barral report on all internationally marketed new drugs concluded that only 11% were therapeutically and pharmacologically innovative.13 Since the mid-1990s, independent reviews have also concluded that about 85-90% of all new drugs provide few or no clinical advantages for patients.14-19 This small, steady increase in clinically superior drugs contrasts with the FDA granting “priority” review status to 44% of all new drugs from 2000 to 2010.20 The percentage of drugs with a priority designation began to increase in 1992 when companies started funding the FDA’s approval process. Other regulatory agencies have classified far fewer of the same medicines as needing accelerated reviews.21 Post-market evaluations during the same period are much less generous in assigning significant therapeutic advances to medications.18 21 This is the real innovation crisis: pharmaceutical research and development turns out mostly minor variations on existing drugs, and most new drugs are not superior on clinical measures. Although a steady stream of significantly superior new drugs enlarges the medicine chest from which millions benefit, medicines have also produced an epidemic of serious adverse reactions that have added to national healthcare costs.22 How much does research and development cost? Although the pharmaceutical industry emphasises how much money it devotes to discovering new drugs, little of that money actually goes into basic research. Data from companies, the United States National Science Foundation, and government reports indicate that companies have been spending only 1.3% of revenues on basic research to discover new molecules, net of taxpayer subsidies.23 More than four fifths of all funds for basic research to discover new drugs and vaccines come from public sources.24 Moreover, despite the industry’s frequent claims that the cost of new drug discovery is now $1.3bn (£834m; €1bn),25 this figure, which comes from the industry supported Tufts Center,26 has been heavily criticised. Half that total comes from estimating how much profit would have been made if the money had been invested in an index fund of pharmaceutical companies that increased in value 11% a year, compounded over 15 years.26 While used by finance committees to estimate whether a new venture is worth investing in, these presumed profits (far greater than the rise in the value of pharmaceutical stocks) should not be counted as research and development costs on which profits are to be made. Half of the remaining $0.65bn is paid by taxpayers through company deductions and credits, bringing the estimate down to one quarter of $1.3bn or $0.33bn.27 The Tufts study authors report that their estimate was done on the most costly fifth of new drugs (those developed in-house), which the authors reported were 3.44 times more costly than the average, reducing the estimate to $90m. The median costs were a third less than the average, or $60m.

## Part 2: Substance

#### Advantage 1] Premium Spikes

#### High drug prices cause premium spikes for insurances. Mammoser 18:

Gigen Mammoser, Healthline, 07-28-2018 [Drug Price Increases and Your Health, https://www.healthline.com/health-news/rising-drug-prices-risk-to-your-health, 10-25-2018]//DW

**Drug price increases also greatly outpace healthcare inflation costs**, which have been [comparatively low in the past few years](https://www.bloomberg.com/news/articles/2018-02-12/a-long-era-of-low-health-care-inflation-may-be-coming-to-end). These **price increases affect insurance premiums and out of pocket expenses**, but it’s hard to say exactly how much. However, Jonathan Gruber, a professor of economics at the Massachusetts Institute of Technology and president of the American Society of Health Economists, says the overall direction is clear. “**Higher drug prices translate to higher health insurance costs for all of us**,” he says. He notes the convoluted system of rebates and discounts between pharmaceutical companies, pharmacy benefit managers, and insurance companies makes things even more murky. “Obviously, **if they raise the price, that’s going to pass through to some extent to consumers**. Whether PBMs are helping or hurting is still unclear, it all depends on how these rebates play through,” says Gruber. “We just don’t know yet. When they raise the price, how much of that is actually making its way to consumers?” PBMs in particular fell under heavy public scrutiny last year when **a woman in California discovered that by using her insurance co-payment,** [**she was actually paying nearly double**](https://www.healthline.com/health-news/may-be-paying-more-for-prescription-drugs-if-using-insurance#1) **for a generic drug than if she would’ve paid out of pocket**. Class action lawsuits have since been filed in several states against national pharmacies including Walgreens and CVS for these practices.

#### And, innovation also spikes premiums. AARP 17:

\*140 dollar spike is about a 30-35% spike based on average premium costs

Aarp Bulletin, May 2017, AARP, May 2017 [Why Prescription Drugs Cost So Much, https://www.aarp.org/health/drugs-supplements/info-2017/rx-prescription-drug-pricing.html, 10-25-2018]//DW

It’s not just people like Huston who suffer financially. “**High prescription drug prices affect everyone**,” Purvis says. “Even if patients are fortunate enough to have good health care coverage, **higher prices translate into higher out-of-pocket costs, premiums** and deductibles. And greater spending by taxpayer-funded programs like Medicare and Medicaid are eventually passed along to all Americans in the form of higher taxes, cuts to public programs or both.” Put even more simply: **One reason that your health insurance rates are high is because you are subsidizing other people’s high-cost medicines**. For example, imagine the euphoria **if a company developed a breakthrough** **treatment** for Alzheimer’s disease. Let’s say it **[that] costs $60,000 a year** per patient, and it gets prescribed to every American with the disease. **To pay for the medicine, insurance premiums for each privately insured person in the U.S. would increase by more than $140 per month**, based on a new calculator developed by the Biotechnology Innovation Organization.

#### And, premium hikes cause people to drop insurance. Baicker 05:

Katherine Baicker and Amitabh Chandra, National Bureau of Economic Research, February 2005 [The Labor Market Effects of Rising Health Insurance Premiums, https://www.nber.org/papers/w11160.pdf]//DW

In the United States, two-thirds of the non-elderly population is covered by employerprovided health insurance (EHI), either directly or as a dependent through a family member’s coverage.1 According to a national survey conducted by the Kaiser Family Foundation, the **cost** of EHI **has increased by over 59 percent since 2000 with no accompanying increase in the scale or scope of benefits; between 2003 and 2004 the price of premiums increased 11.2 percent**, a nine percentage point increase over the 2.3 percent increase in workers’ hourly earnings.2 Increases in health insurance premiums may have significant effects on labor markets, including changes in the number of jobs, hours worked per employee, wages, and compensation packages. Indeed, it is possible that a significant portion of the increase in the uninsured population may be a consequence of employers shedding this benefit as health-insurance premiums rise (Porter, 2004). Simple correlations are consistent with this mechanism: **despite strong economic growth in the 1990s, the number of** non-elderly **uninsured grew** by 3 percentage points **to 15.7 percent of the population**, while the price of health-insurance premiums grew by 34 percent.

#### That puts millions at risk of death. Chalabi 17:

Mona Chalabi, Guardian, 6-24-2017 [Will losing health insurance mean more US deaths? Experts say yes, https://www.theguardian.com/us-news/2017/jun/24/us-healthcare-republican-bill-no-coverage-death, 10-25-2018]//DW

The two sets of numbers allowed the researchers to examine something called [hazard ratios](http://www.statisticshowto.com/hazard-ratio/), which are a way to measure risk. For example, if a clinical trial finds that drug users are three times more likely experience a certain side effect, that drug has a hazard ratio of three. In America, deep inequality can affect the usefulness of data like this. Lots of things can increase an American’s chances of being sick – being a person of color or being poor to name just two – and if those factors overlap with a lack of health insurance, it can be difficult to determine what exactly is affecting an individual’s risk of death. **In the Harvard study, the researchers had 9,000 people in their dataset – enough that they were able to ensure they were really measuring the impact of a lack of health insurance**. The researchers found that a **lack of health insurance had a mortality hazard ratio of 1.40. In other words**, they concluded that **Americans without health insurance were 40% more likely to die than those with it, even after taking into account the individual’s “gender, age, race/ethnicity, poverty income ratio, education, unemployment, smoking, regular alcohol use, self-rated health, physician-rated health and body mass index**”. The researchers calculated that in 2005, lack of health insurance resulted in 44,789 deaths of Americans age 18 to 64.

#### Advantage 2] Opioids

#### Pharma companies are a major contributer to the opioid crisis. Stojsavljevic 18:

Andrea Stojsavljevic, Advocacy Fellow, Healthier Colorado, 4-3-2018 [The Opioid Crisis: Holding Pharmaceutical Companies Accountable, https://healthiercolorado.org/blog-post/opioid-crisis-holding-pharmaceutical-companies-accountable/, 10-25-2018]//DW

Purdue **Pharma began attempting to shift how physicians and the public perceived opioids starting in the 1990s**.7 For one, **Purdue funded medical professionals to speak on how doctors should not fear the use of opioids**, placed statements in Medical journals downplaying opioids’ potential for abuse, **and were able to get OxyContin approved by the FDA without any clinical trials** being conducted about how addictive or prone to abuse the drug may be.8 **Purdue also launched one of the largest pharmaceutical marketing campaigns in history, marketing OxyContin as a drug that could be used safely and for long-term periods** for a variety of health and pain issues. They also specifically targeted doctors who were ignorant to the actual effects of opioids.9 These kind of fraudulent and deceptive marketing campaigns have led to Purdue being sued thousands of times over OxyContin.8 One such lawsuit in 2003 was brought by New York trial lawyer Paul Hanley, who declared, “This company had set out to perpetrate a fraud on the entire medical community. These pronouncements about how safe the drug was emanated from the marketing department, not the scientific department. It was pretty shocking. They just made this stuff up.” Purdue settled this particular case, but in 2007 the company pleaded guilty to federal criminal charges of misbranding and acknowledged they had marketed OxyContin with the intent to defraud or mislead. Three Purdue executive also pleaded guilty to criminal charges in that case.10 Purdue led the charge, but many other pharmaceutical companies have followed suit. The founder of **Insys Therapeutics**, John M. Kapoor, was arrested in October of 2017 **and** charged with leading a conspiracy to use bribes and fraud for the illegal distribution of Fentanyl spray. It’s alleged that Kapoor **paid doctors in exchange for prescribing the spray, which contains the powerful and highly addictive opioid fentanyl**.11 Other pharmaceutical companies like Teva, Janssen, Johnson and Johnson, McKesson, and many more are now facing multiple lawsuits claiming they have all used deceptive marketing techniques to sell their drugs.12

#### And, that kills thousands. Fox 18

Maggie **Fox 18** (Maggie Fox, 4-2-2018, NBC News, "Could medical marijuana help fight the opioid abuse epidemic?", <https://www.nbcnews.com/health/health-news/medical-marijuana-may-reduce-opioid-use-little-n862101>, Date Accessed 11-5-2018 CC

Since **opioid prescriptions are** considered to be **a major driver of the opioid abuse epidemic**, the researchers said, **medical marijuana laws could** be a part of **the solution**. “State **implementation of medical marijuana laws was associated with a [6] 5.88 percent lower rate of opioid prescribing**,” wrote Hefei Wen of the University of Kentucky College of Public Health and Jason Hockenberry of the Emory University Rollins School of Public Health. “**Marijuana is one** of the **potential non-opioid alternatives that can relieve pain at** a relatively lower risk of addiction and virtually **no risk of overdose**,” they wrote in one of two reports published in the Journal of the American Medical Association’s [JAMA Internal Medicine.](http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/10.1001/jamainternmed.2018.1007) The researchers looked at the prescription records of people using Medicaid and also Medicare Part D – the prescription add-on plan for Medicare recipients. In the Medicare study, Wen and colleagues found that **states with medical marijuana laws had a more than 8 percent reduction in opioid prescriptions** compared to states with no such laws. “We found that overall opioid prescribing in Part D was lower when states permit access to medical cannabis,” they wrote. “Prescriptions filled for all opioids decreased by 2.11 million daily doses per year from an average of 23.08 million daily doses per year when a state instituted any medical cannabis law,” they added. “Prescriptions for all opioids decreased by 3.742 million daily doses per year when medical cannabis dispensaries opened.” State and federal officials are looking for ways to reduce opioid deaths and to reduce the overuse of opioid prescriptions. The National Center for Health Statistics says **63,600 people died of**[**drug overdoses**](https://www.nbcnews.com/storyline/americas-heroin-epidemic/teen-drug-overdoses-doubled-1999-2015-cdc-reveals-n793006)**in 2016.**

#### And, price controls force companies’ priorities into developing drugs for the common good. Conti 16:

Conti 16 - Associate Professor in the Departments of Pediatrics and Public Health Sciences at the University of Chicago (Rena, “THE ADVANTAGES OF AWARDING THE FEDERAL GOVERNMENT NEGOTIATING POWER OVER THE PRICES OF PRESCRIPTION DRUGS,” Journal of Policy Analysis and Management, DOI: 10.1002/pam)//DW

The most common argument against these proposals is centered on the “value of innovation.” Critics argue the short- to medium-term implication of these policies’ adoption in the U.S. may be quite negative, as consolidated government purchasing policies for many goods can lead to stagnant investment in innovation (Lakdawalla & Sood, 2007). Given the centrality of the public programs, pharmaceutical manufacturers would not be able to walk away from an unsatisfactory pricing deal with the federal government (a variant on the hold-up problem). They argue that U.S. investment powers innovation that on average saves lives and improves morbidity worldwide, leading to substantial economic growth and opportunity. They question why public policymakers would want to “fix” prices in the middle of an unprecedented wave of new prescription drug launches with a promise of more to come. I find these arguments weak. None of the proposals would transfer price negotiation to the federal government for all national prescription drug purchases. Consequently, under the general rubric of this policy the U.S. government would not become the sole monopsonistic purchaser of prescription drugs, reducing (but not obviating) the potential hold-up concerns. Under the assumption that neoclassical economic theory holds, **reducing prescription drug prices** should act to **increase** American patients’ **demand** for prescription drugs, in effect **allowing pharma**ceutical **manufacturers to recover** demand reduced or shut out of consumption under the current high price regime. **This policy would reinforce pharmaceutical manufacturers’ incentives to innovate for the American market**: even under the current policy regime the U.S. consumes more health and wellness goods per capita than any other OECD country and makes up 40 percent of all prescription drug purchases worldwide. **Such a policy would** act in concert with other federal policies that **incentivize** physicians to treat disease with “**cost-effective” prescription drugs**, including new physician reimbursement policies in fee-for-service Medicare involving pathways or bundled payments (Conti et al., 2016). **What this policy would do is change the willingness of federal purchasers to pay for prescription drugs with very high price tags** and (largely) limited clinical value. Under such a policy, it is entirely possible prices would be lowered in some drug classes and raised in others with significant value, including prescription drugs that extend life among American patients suffering from dread disease. This policy also addresses an important market failure related to moral hazard— financial returns in the biotech sector over the past decade have been spectacular, **suggesting** overinvestment in **this area and underinvestment in other promising areas of discovery**. Much (not all) of **current financing throws** good money after bad, **producing** novel **drugs with limited gains** in effectiveness and crowded therapeutic classes in niche product areas (e.g., the oral tyrosine kinase inhibitors and more recently launched PD1 inhibitors). Unlike “blockbuster” mental health drugs launched in the mid- to late-1990s (atypical antipsychotics, SSRI/SNRI, and other antidepressants), current innovation in many specialty therapeutic classes targets diseases for which patient heterogeneity in underlying disease etiology or treatment response does not appear significant enough to justify the value of this redundancy. While the average value of pharmaceutical innovation may be significant to improving patient health, the marginal impact of much of this innovation is minimal. Consequently, more coordinated **pricing policy among** federal payers in this market **would** likely act to **promote** and sustain **competition among** pharmaceutical **manufacturers investing in drug discovery that** furthers public health goals more broadly. Rising prices in some areas would act to “pull” investment from academia and the private sector, leading to targeted drug discovery. Finally, nothing about this policy guarantees that federal government support for research would stay fixed at current levels of investment. If private sector investment and innovation waned considerably after such a policy’s enactment, particularly among specific populations or diseases, the U.S. Congress could step in to increase public funding for translational work and basic science meeting public health goals, as it has done repeatedly over the past decades. Indeed, at the societal level additional reimbursement to innovators willing to engage in specific types of development may be warranted outside of the current patent system. These payments could be the responsibility of government, or potentially global nonprofit consortia, similar to that currently pursued for vaccine advanced market commitments (Berndt & Hurvitz, 2005). For example, the U.S. could provide cash payments, tax rebates, subsidies, or reductions in time to initial drug approval in exchange for specific drug development. The innovation rewards could come before, at, or after drug launch; such a proposal was recently considered by the U.S. Senate in 2013 (U.S. Senate bill S.627, the Medical Innovation Prize Fund Act). I do acknowledge that such a policy would fundamentally change the operations of many branded pharmaceutical manufacturers. For example, it is likely that under increased pricing pressure, pharmaceutical manufacturers would face stronger incentives to reduce inefficiency and redundancy. In turn, internal decisionmaking and external financing arrangements would have to evolve to prioritize and support “valuable” drug development. Given our democratic process, pharmaceutical manufacturers would undoubtedly act as strong participants in the design of the policy ensuring minimal operational and profit harms. To ensure the robust competitiveness of and returns on investments this sector, Wall Street too would be an active participant in both crafting legislation that minimally reduced potential returns on investment and coming up with new ways to finance prescription drug development.

#### No shift to marketing—that disadvantages them. Lexchin 04:

Donald Light, Joel Lexchin, Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet, 2004, *The American Journal of Bioethics,* 10-31-2018, [http://www.pnhp.org/sites/default/files/docs/Lower-Drug-Prices-Jeopardize-Drug-RD.pdf]//DW

**If American prices were cut in half, research budgets would not** have to **suffer unless executives decided to cut them in favor of marketing, luxurious managerial allowances or high profits. They probably would not, because R&D gets such favorable tax treatment** compared to other expenses. **Lower prices would save other Fortune 500 companies billions in drug benefit costs**, and drug company profits could come into line with the profits of the companies who pay for their drugs.

#### Advantage 3] Prescription Fills

#### High costs cause Americans to ignore prescriptions. RUN 15

**RUN 2015 reports:** (Renal and Urology News 2-4-2015, RUN, Almost 1 in 10 Americans Can't Afford Medications Says CDC, https://www.renalandurologynews.com/news/cdc-americans-can-not-afford-medications-eight-percent/article/395374/, accessed 10-18-2018) CC

**Nearly 1 in 10 American adults don't take their**[**medications**](http://www.renalandurologynews.com/drug-showcase/section/3546/)**as prescribed because they can't afford to**, **according to a January data brief published by the U.S. Centers for Disease Control and Prevention's National Center for Health Statistics.**

#### Americans Don’t Fill prescriptions on drugs they desperately need

Prescription Justice, 2-6-2017, "45 Million Americans Forego Medications Due to Costs, New Analysis Shows – 9 Times the Rate of the UK," https://prescriptionjustice.org/press\_release/45-million-americans-forego-medications-due-to-costs-new-analysis-shows-9-times-the-rate-of-the-uk/ASJ

About 45 million Americans did not fill a prescription in 2016 due to the costs of pharmaceuticals, a new analysis by Prescription Justice shows, with 18% of adults reporting this problem in a recent survey. This rate of foregoing medicine due to cost is nine times higher than in the United Kingdom, where medicine is largely covered by national health insurance. The analysis conducted by Prescription Justice —a non-profit organization dedicated to tackling the crisis of high drug prices — is based on data extracted from the Commonwealth Fund’s 2016 International Health Policy Survey of Adults. “Americans cannot afford to wait a day longer for drug price relief,” said Jodi Dart, Executive Director of Prescription Justice. “Tens of millions of Americans are not taking medications because of high drug prices. We urge President Trump to keep his campaign promise to stand up to big pharma and bring relief to millions of Americans who are unduly suffering because they can’t afford the vital medications that they need.” The data also show a likely link between the advent of the Affordable Care Act and the percentage decrease in people who have had to forego prescription medication due to cost in recent years. Prior to ACA implementation, 21% of Americans reported not filling prescriptions due to cost. That number has dropped three percentage points since the Affordable Care Act took effect in late 2013.

#### **And, that causes death. Boylan 17**

Lisa Boylan of the NACDS in 2017 reports: (Lisa Boylan, 04-20-2017, The Cost of Medication Non-Adherence, <https://www.nacds.org/news/the-cost-of-medication-non-adherence/>, accessed 11-9-2018) NC

The New York Times [reported](https://www.nytimes.com/2017/04/17/well/the-cost-of-not-taking-your-medicine.html?rref=collection%2Fsectioncollection%2Fhealth&action=click&contentCollection=health&region=stream&module=stream_unit&version=latest&contentPlacement=1&pgtype=sectionfront&_r=1) this week on an “out of control epidemic” in the U.S. that costs more and affects more people in the U.S. than any disease Americans are concerned about right now—and it is 100 percent preventable. The culprit? Medication non-adherence. A [review](http://annals.org/aim/article/1357338/interventions-improve-adherence-self-administered-medications-chronic-diseases-united-states) in the Annals of Internal Medicine estimates that a lack of adherence causes nearly 125,000 deaths, 10 percent of hospitalizations and costs the already strained healthcare system between $100–$289 billion a year. The article points to findings from studies NACDS has often referenced in advocacy efforts to improve medication adherence—including that 20–30 percent of medication prescriptions are never filled and approximately 50 percent of medications for chronic disease are not taken as prescribed. Significantly, the study authors found the strongest evidence yet that improved medication adherence was accompanied by pharmacist-led high blood pressure management. In addition, the study showed that “education with behavioral support; reminders; and pharmacist-led, multicomponent interventions enhanced adherence…”

## Part 3: Solvency

#### Price Controls Reduce Prices by 50% making drugs more accessible

Physicians for a National Health Program, 2017, Estimated Effects of Proposed Reforms on US National Pharmaceutical Expenditures, 2017, [Accessed 11-01-2018, http://www.pnhp.org/sites/default/files/Pharma\_Table7.pdf]//DW+ASJ

Finally, our estimate is supported by the lower prices paid by the US Veterans Health Administration (VA), which negotiates for drug prices and maintains a formulary. A dated estimate from the Congressional Budget Office puts prices paid by the VA for branded drugs at 42% of the average wholesale price.53 Frakt et al., drawing on four studies, assert that the VA obtains drug prices approximately 60% of those paid by Medicare.54 Together, these estimates accord with our estimate of an approximately 50% reduction in drug prices through negotiations and a formulary. It seems likely that the prices paid by these programs would also be reduced, albeit to a lesser extent. **We apply the estimated 17% increase in drug spending from eliminating cost-sharing to our estimate of total drug spending after adjustment for a 50% reduction** in brand-name drug prices for non-discounted payers (i.e. total current estimated 2017 drug spending of **$500.1 billion minus [there would be] estimated savings of $154.6 billion**). Since this includes spending on inpatient drugs (the utilization of which would likely be less affected by the elimination of cost-sharing), our spending estimate likely overstates the cost of eliminating cost-sharing.

**This is empirically confirmed**

#### FIND ACCESSBILITY OF DURGS IN EU COMPARED TO US

#### Europe R&D has increased despite price controls. Lexchin 04:

Donald Light, Joel Lexchin, Will Lower Drug Prices Jeopardize Drug Research? A Policy Fact Sheet, 2004, *The American Journal of Bioethics,* 10-31-2018, [http://www.pnhp.org/sites/default/files/docs/Lower-Drug-Prices-Jeopardize-Drug-RD.pdf]//DW

**On the contrary, audited financial reports of major drug firms in the UK, show that all research costs are paid, with substantial profits left over**, based solely on domestic sales at British prices (Pharmaceutical Price Regulation Scheme 2002). Likewise, 79 research drug companies in Canada submitted reports showing **their R&D expenditures have risen more than 50% since 1995**, all paid for by domestic sales at Canadian prices (Patented Medicine Prices Review Board 2002). Sales to the U.S. and elsewhere are in addition to the positive, domestic balance sheets.

\facts above (Safire 2003).