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**We Affirm Resolved:** The United States federal government should impose price controls on the pharmaceuticals industry

## Contention One is Helping Hospitals

Currently, **Pollack of the University of Chicago[[1]](#footnote-1)** finds that hospitals bear a heavy financial burden when the cost of drugs increases, because they are the ones who buy prescriptions and medicine in bulk. Unfortunately, this has implications to the entire hospital. **Dennis of the Chicago Tribune writes in 2016[[2]](#footnote-2)** that hospitals run on razor-thin margins, and when anything upsets the sensitive system, the whole hospital is thrown off. As a result, **Lupkin of Boston University writes in 2016[[3]](#footnote-3)** that hospital closures seem to be more common than ever before, and rising drug prices are responsible for much of the current trend. This is why **Ellison[[4]](#footnote-4)** explains that in the last 8 years, over 85 hospitals have closed in rural areas

### The Impact is Preventing loss in Rural America

Currently, **iVantage Health Analytics** **writes in 2016[[5]](#footnote-5)** that over 600 hospitals in rural areas are at risk of closure. If the status quo continues, these hospitals would be squeezed out of profits and forced into closure. This is problematic, as they write that these hospitals serve as “critical access” points of care to more than 62 million people in the country, and the loss of these hospitals would put thousands of lives at risk, 200,000 jobs lost, and a 300-billion-dollar loss to our GDP over 10 years. Unfortunately, **Nicholl[[6]](#footnote-6)** in 2007 finds that a 10-km increase in distance is associated with 1% increase in mortality and hurts minorities and low-income the worst: By affirming, we can prevent hospitals from closing due to high drug prices.

## Contention Two is Ensuring the Price is Right

**A crisis exists in the status quo. Hirschler of Scientific American[[7]](#footnote-7)** explains that Americans pay 3 times more for drugs than its foreign counterparts, with drug prices in America rising every year. **Gillian of ABC News[[8]](#footnote-8)** empirically finds, that even the costs of generic medications are rising by 448%. This trend must be reversed, or else **Sanders of the Huffington Post[[9]](#footnote-9)** finds in 2015 that drug costs will on average rise by 10 percent per year for the next 10 years.

**Lupkin of Kaiser Health[[10]](#footnote-10)** notes that the “most important factor” that drives prescription drug prices higher in the United States than anywhere else in the world is the existence of government-protected “monopoly” rights for drug manufacturers. Furthermore, **Konca in 2016[[11]](#footnote-11)** finds that the pharmaceutical industry is becoming more monopolized day by day, with ten companies controlling half the industry. This is because **Deangilis of the NIH[[12]](#footnote-12)** finds that without any regulation, the government allows them to operate at massive profit margins, handing these corporations any tools they need to crowd out competition. Problematically, **Johnson of The Washington Post[[13]](#footnote-13)** writes that the new administration has not and will not make any moves against pharmaceutical companies.

This allows the cycle of price spikes. **Baker of the New York Times[[14]](#footnote-14)** analyzes that Drug companies spend tens of millions on campaign contributions and lobbying to get every longer and stronger patent protection, allowing them to strengthen their monopoly, and unnecessarily spike drug prices.

However, price controls will check back monopolies.

**Mintzberg of NIH[[15]](#footnote-15)** explains that firm price regulations, including price controls, are the strongest way to check back pharmaceutical monopolies, as they can no longer use their advantages to keep prices high due to a strict price cap.

### The impact is accessibility

**Levy[[16]](#footnote-16)** finds that a pharmaceutical price cap at 20% lower than the monopolistic price increases the consumer surplus by 10% and increases the number of patients using the drug by 23%. He furthers that this increase in the number of users almost completely offsets the adverse effect of the price regulation, as its revenues only decrease by 1%. These reductions in price has worked empirically, as **Sarnak of The Commonwealth Fund[[17]](#footnote-17)** reports that the only developed countries where patients were not likely to report cost barriers to prescription drugs were countries that have implemented price controls.

This is crucial, as **Healthcare Financial ’17[[18]](#footnote-18)** finds that half of all Americans do not take their medications as prescribed and more than 20 percent of new prescriptions go unfilled-and the main reason is cost. As a result, the lack of adherence to these medications causes approximately 125,000 deaths[[19]](#footnote-19) and at least 10 percent of hospitalizations each year.

Increasing access by 23% will help 33 million people across the United States, which is why Kempner Affirms.

1. ####  Hospital Bear costs

Richard Pollack, University of Chicago, Wed Oct 03 2018, https://www.aha.org/system/files/2018-01/aha-fah-rx-report.pdf

These price increases are extremely troublesome throughout the health care system. They not only threaten patient access to drug therapies, but also challenge providers’ abilities to provide the highest quality of care. Drug costs also are a major factor in the rising cost of health care coverage. H**ospitals bear a heavy financial burden when the cost of drugs increases and must make tough choices about how to allocate scarce resources**. One hospital put the challenge starkly: last year, the price increases for just four common drugs, which ranged between 479 and 1,261 percent, cost the same amount as the salaries of 55 full-time nurses. And while nearly everyone can agree that price increases in the hundreds or thousands of percent are unjustifiable, many **hospitals report that annual price increases of 10 or 20 percent on widelyused older generic drugs can have an even greater effect, given the large quantities that a hospital must purchase**. Managing these skyrocketing cost increases forces difficult choices between providing adequate compensation to employees, many of whom are highly skilled in professions facing shortages; upgrading and modernizing facilities; purchasing new technologies to improve care; or paying for drugs, especially when these price increases are not linked to new therapies or improved outcomes for patients. [↑](#footnote-ref-1)
2. ####  Hospitals have small margins

Brady Dennis, Chicago Tribune, "Rattled by drug price increases, hospitals struggle with costs, care - Chicago Tribune", Tue Nov 27 2018, https://www.chicagotribune.com/business/ct-hospitals-drug-price-increases-20160314-story.html

That's a challenge, given the 6,000 medications the nonprofit system purchases. Hence the addition of "$$$$$" in its electronic records to alert physicians about which are most expensive. Like other facilities, the system dropped multiple budget-busters from its formulary. Osborne said he now pays as much attention to news about pharmaceutical mergers and acquisitions each week as he does to academic articles about medicines. "**Hospitals run on razor-thin margins. When you get surprises, it throws everything off," he said. "As they say, 'No margin, no mission.**' " Big data offers new way to find hidden drug interactions Other hospitals have found additional ways to chip away at high drug costs. At the University of Utah Health Care system, administrators pulled Isuprel off about 100 mobile "crash carts" after its price skyrocketed, said Erin Fox, director of drug information service. Doctors now must specifically request it from the hospital pharmacy. "Our physicians are pretty annoyed at having to make clinical decisions about drugs they've used forever based on cost," Fox said. "With some of these drugs, there just aren't good alternatives. That's what makes it really frustrating." [↑](#footnote-ref-2)
3. ####  Hospitals Closing faster than before

Sydney Lupkin, Boston Univeristy, "Hospitals Say They’re Being Slammed By Drug Price Hikes | Kaiser Health News", Tue Nov 27 2018, https://khn.org/news/hospitals-say-theyre-being-slammed-by-drug-price-hikes/

David Vandewater, president and CEO of Ardent Health, which includes 14 hospitals, pointed out **that hospital closures seem to be more common than ever before**. And although greedy drug companies aren’t 100 percent at fault, they may share some of the blame for this trend, he said. When companies hike drug prices, hospitals lose money on insured patients, but make money on uninsured or out-of-network patients because they can legally charge a markup for drugs, said Gerard Anderson, a health policy and management professor at Johns Hopkins Bloomberg School of Public Health. Drugs are regularly marked up at least 500 percent, so if the drug price is higher, so is the profit. [↑](#footnote-ref-3)
4. <https://www.beckershospitalreview.com/finance/state-by-state-breakdown-of-85-rural-hospital-closures.html>

Of the 26 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to [research](http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/) from the North Carolina Rural Health Research Program.

Fourteen hospitals in Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with eight hospitals closing since 2010. In third place is Georgia with six closures, followed by Alabama, Mississippi and North Carolina, which have each seen five hospitals close over the past eight years.

**Listed below are the 85 rural hospitals that closed between January 2010 and July 2018**, as tracked by the NCRHRP. For the purposes of its analysis, the NCRHRP defined a hospital closure as the cessation in the provision of inpatient services. As of July 3, 2018, all of the facilities listed below had stopped providing inpatient care. However, some of them still offered other services, including outpatient care, emergency care, urgent care or primary care. [↑](#footnote-ref-4)
5. ####  Hospitals at risk of closing

IVantage Health Analytics, "Rural Relevance- Vulnerability To Value", Sun Oct 08 2017, http://cdn2.hubspot.net/hubfs/333498/2016\_INDEX\_Rural\_Relevance/INDEX\_2016\_Rural\_Relevance\_Study\_FINAL\_Formatted\_02\_01\_16.pdf?\_\_

In November 2015 iVantage leveraged a fully updated and expanded data set to re-assess the performance of rural hospitals across all indicators, and compare these findings to the performance characteristics of the 62 hospitals which have closed since 2010 (thru year-end 2015**). iVantage research now identifies 673 rural hospitals in the Vulnerability Inde**x. These facilities fall into two groups: 210 hospitals are most vulnerable to closure, while an additional 463 are less vulnerable, but still very much at-risk. Acknowledging that hospital closures are not solely based on financial performance, but a combination of factors which include loss of market share, patient volume, and declining quality, outcomes and satisfaction, the INDEX strives to provide a holistic view of operations to determine overall stability. The significant increase in the number of hospitals in the Vulnerability INDEX is indicative of the complex – and growing – challenges facing this segment of healthcare. Policy changes concerning Medicare reimbursement pose a particular threat to the rural health safety net relied upon by millions of Americans for their healthcare needs. Through its research, iVantage has quantified the impact that several of these changes have had (or may have) on rural healthcare institutions. Sequestration, charity care/bad-debt reimbursement cuts, disproportionate share payment cuts, and the uneven adoption of Medicaid expansion under the Affordable Care Act have created significant downward pressure on rural hospital margins. Additional cuts, which have been proposed - such as the OIG

#### Impact of closure

IVantage Health Analytics, "Rural Relevance- Vulnerability To Value", Sun Oct 08 2017, http://cdn2.hubspot.net/hubfs/333498/2016\_INDEX\_Rural\_Relevance/INDEX\_2016\_Rural\_Relevance\_Study\_FINAL\_Formatted\_02\_01\_16.pdf

However, the rural health safety net continues to operate in a complex socioeconomic, demographic, regulatory and reimbursement environment with numerous challenges. Since 2010, more than 60 rural communities have experienced a hospital closure and our 2016 analysis suggests that the situation is worsening for many rural communities. The Hospital Vulnerability Index™ has identified 673 facilities which are now vulnerable or at risk for closure. The loss of an immediate – or local – point of care can have a lasting impact on a community. **iVantage modeled the potential impact on those communities in the event these 673 hospitals identified as ‘vulnerable’ or ‘at risk’ were to close and estimates**: ** 11.7 million Patient Encounters  99,000 Healthcare Jobs Lost  137,000 Community jobs Lost  $277 billion Loss to GDP (10 years)** [↑](#footnote-ref-5)
6. <https://sci-hub.tw/10.1136/emj.2007.047654> [↑](#footnote-ref-6)
7. **Hirschler** , Ben. “How the U.S. Pays 3 Times More for Drugs.” **Scientific American**, **2017**, [www.scientificamerican.com/article/how-the-u-s-pays-3-times-more-for-drugs/](http://www.scientificamerican.com/article/how-the-u-s-pays-3-times-more-for-drugs/)

**U.S. prices for the world's 20 top-selling medicines are, on average, three times higher than in Britain,** according to an analysis carried out for Reuters. The finding underscores a transatlantic gulf between the price of treatments for a range of diseases and follows demands for lower drug costs in America from industry critics such as Democratic presidential candidate Hillary Clinton.

https://www.huffingtonpost.com/bernie-sanders/high-drug-prices-are-kill\_b\_8059526.html

That should not be happening in the United States of America — but it is. And it’s not likely to end anytime soon, unless we do something. Medicare is predicting that **drug costs will continue to rise by nearly 10 percent per year for the next 10 years.** Tens of thousands of Americans now spend more than $100,000 a year on prescription medication. One drug costs $1,000 per pill. [↑](#footnote-ref-7)
8. Mohney, **Gillian**. “Generic Drug Price Sticker Shock Prompts Probe by Congress.” **ABC News**, ABC News Network, 21 Nov. **2014**, [abcnews.go.com/Health/generic-drug-prices-skyrocketing-lawmakers-warn/story?id=27060992](http://abcnews.go.com/Health/generic-drug-prices-skyrocketing-lawmakers-warn/story?id=27060992)

The hearing of the Senate subcommittee on primary health and aging on Thursday was called after Vermont Sen. Bernie Sanders and Maryland Rep. Elijah Cummings announced they were investigating why some generic drug prices have risen hundreds to thousands of percent -- putting a severe strain on the pocketbooks of many people who rely on generics to reduce costs compared to brand-name drugs. To combat the rising prices, Sanders said he was introducing a bill that would require generic drug makers to pay a rebate to Medicaid if the cost increases faster than inflation. **The prices of more than 1,200 generic medications increased an average of 448 percent** between July 2013 and July 2014, Sanders said during the hearing, citing federal records. [↑](#footnote-ref-8)
9. https://www.huffingtonpost.com/bernie-sanders/high-drug-prices-are-kill\_b\_8059526.html

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10. Sydney Lupkin, 8-23-2016, "5 Reasons Prescription Drug Prices Are So High in the U.S.," Money, <http://time.com/money/4462919/prescription-drug-prices-too-high/>

The “most important factor” that drives prescription drug prices higher in the United States than anywhere else in the world is the existence of government-protected “monopoly” rights for drug manufacturers, researchers at Harvard Medical School report today. [↑](#footnote-ref-10)
11. **In fact, Konca of the International Journal of Business writes that the pharmaceutical industry becomes more monopolized every day, with only 10 companies controlling half the industry.**

**The pharmaceutical and biotechnology industry has become more concentrated day by day.** For example; while the share of **10 biggest companies in the word carrying on business in the pharmaceutical sector in the middle of 1980s was 20%, this ratio has reached to 50% in the beginning of 2000s.** The company mergers may be shown as the most significant reason of this situation (Danzon et al., 2007). The value of company mergers and acquisition within the relevant dates exceeded 5000 billion dollars (Danzon et al., 2007). The merger, acquisition or co-marketing agreements concluded between the pharmaceutical companies occur as a result of capacities of the relevant companies in terms of completing each others. [↑](#footnote-ref-11)
12. <https://www.cnbc.com/2018/06/25/high-drug-prices-caused-by-us-patent-system.html> [↑](#footnote-ref-12)
13. Carolyn **Johnson**., 11-24-2017, Washington Post, "Analysis", (), accessed 10-28-**2018**, <https://www.washingtonpost.com/news/wonk/wp/2017/11/24/the-trump-administration-is-taking-on-drug-prices-but-not-drug-companies>

“This is another demonstration that despite rhetoric, **action in DC continues to favor the drug industry**,” Gal wrote in a note to investors. **The Trump administration's connections to the pharmaceutical industry have triggered scrutiny.** Trump's nominee to head Health and Human Services, [Alex Azar](https://www.washingtonpost.com/news/wonk/wp/2017/11/13/trumps-pick-to-lower-drug-prices-is-a-former-pharma-executive-who-raised-them/), is a former pharmaceutical executive. Another former industry insider, Scott Gottlieb, heads the Food and Drug Administration. [↑](#footnote-ref-13)
14. [↑](#footnote-ref-14)
15. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1534100/

The problem of high pharmaceutical prices is not without solutions. Many are obvious enough, and some have been implied in this article, including firmer regulation of pricing, the use of independent clearinghouses for balanced information on products, research efforts more widely spread across different types of institutions, and a stop to direct-to-consumer advertising. However, there is a lack of sufficient will to confront the problem directly, in part because of the power of the industry and its influence on political processes. The current situation in the patent-dependent pharmaceutical industry is not just unacceptable, it is shameful. It will remain so until concerned citizens gather the energy to change it. [↑](#footnote-ref-15)
16. Moshe **Levy 14** & Rizansky Nir, A. (2014). The Pricing of Breakthrough Drugs: Theory and Policy Implications. PLoS ONE, 9(11), e113894. doi:10.1371/journal.pone.0113894

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4244177/

Thus, the model provides a theoretical foundation and benchmark for setting price caps. The model allows us to quantify the costs and benefits of **drug price regulation**. We find that mild price regulation can substantially increase consumer surplus and the number of patients using the drug while having only **a**second-order effect of the revenues of the **pharmaceutical** companies. For example, setting **the price cap** **at 20% lower than the optimal monopolistic price increases the consumer surplus by about 10%, and** **increases the number of patients using the drug by about 23%.** **This increase in the number of users almost completely offsets the adverse effect of the price regulation** from the perspective of the pharmaceutical company – **its revenues decrease by only about 1%.**However, more aggressive price regulation leads to a substantial revenue reduction and may stifle innovation. The price caps in OECD countries, which are up to 67% lower than the U.S. unregulated prices, lead to a lower ratio between the consumer surplus and the loss of revenue for the pharmaceutical company, and thus certainly seem excessive. There seems to be a ‘‘golden path’’ of mild regulation that on the one hand greatly improves patient welfare, and on the other hand does not stifle the pharmaceutical industry and the important economic incentive for drug innovation [↑](#footnote-ref-16)
17. <https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/paying-prescription-drugs-around-world-why-us-outlier>

Notably, the only countries where such patients were not significantly more likely to report cost barriers to prescription drugs were France, Germany, and the U.K. — countries that have instituted protections to reduce out-of-pocket charges for their chronically ill populations [↑](#footnote-ref-17)
18. **Connolly**, Ceci. “Skyrocketing Prescription Drug Crisis: Action Needed.” Healthcare Financial Management, **Healthcare Financial Management**, 1 Aug. **2017**, www.highbeam.com/doc/1G1-502119025.html

The U.S. healthcare system faces growing cost pressures due to the unrelenting increase in prescription drug prices. Over the past 20 years, *the cost of medications has more than doubled, from 7 percent to about 17 percent of all healthcare spending.3***Soaring drug prices are both a major contributor to overall healthcare costs and an impediment to providers and health plans looking to appropriately manage total cost of care.** If the trend continues, projections show that this problem will get worse. Patients, health plans, government programs, and other payers spent more than $300 billion on prescription drugs in 4015, and spending is expected to climb to $400 billion in aoso, accordingto IMS Health. **The trend is having a direct impact on patients. Studies show that half of all patients do not take their medications as prescribed and more than 20 percent of new prescriptions go unfilled-and the main reason is cost**. We must address rising drug prices to ensure the healthcare system is sustainable and affordable and works for patients and health plans alike. [↑](#footnote-ref-18)
19. This lack of adherence, the Annals authors wrote, is estimated to cause approximately 125,000 deaths and at least 10 percent of hospitalizations, and to [cost the American health care system](http://www.nejm.org/doi/pdf/10.1056/NEJMp1307084) between $100 billion and $289 billion a year. [↑](#footnote-ref-19)