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Abby and I negate Resolved: The United States federal government should impose price controls on the pharmaceutical industry.

Contention One is Stifling Innovation

The United States is the biggest contributor to pharmaceutical innovation. This is largely because of the lack of price controls.

Patricia Van **Arnum**, 4-13-20**16**, "Biopharmaceutical Innovation: Which Countries Rank the Best?," **Drug, Chemical & Associated Technologies Association,** https://www.dcatvci.org/250-biopharmaceutical-innovation-which-countries-rank-the-best //AM

A recent industry study examines the extent to which the public investment, intellectual property, and **drug pricing policies of 56 countries proactively contribute to or detract from** global life-sciences **innovation**. So what did the report find? **The report finds that the United States places first overall, with policies (on a per-GDP basis) that contribute the most to global biopharmaceutical innovation, followed by Switzerland, Taiwan, Singapore, and Sweden.** T Value Chain Insights (VCI) examines the rankings. The study is based on three main indicators: governments' R&D expenditures on health (measured by the share of government R&D dedicated to health research and government R&D as a share of gross domestic product (GDP); the extent of their price controls on pharmaceutical drugs; and their protections for life-sciences intellectual property (IP), a measured by the period of biologics data exclusivity. The study was conducted by the Information Technology & Innovation Foundation (ITIF), a nonprofit public policy think tank based out of Washington, D.C. focused on public policies that spur technology innovation. The United States ranked first overall. In terms of the specific indicators, it ranked seventh in the government R&D allocated to health research, first with respect to IP protection, and tied for first on the price-controls indicator. **Switzerland, Taiwan, Singapore**, and Sweden **came in second, [third and fourth]** through fifth, respectively, **as a result of** strong government investment in life-sciences research, **low pharmaceutical price controls** for Switzerland, Taiwan, and Singapore, and strong IP protection for Switzerland and Sweden. Overall, the US accounts for the largest funding for global life sciences innovation. Although the US produces about 22% of the global GDP and accounts for 4% of the world's population, it accounts for 44% of global biomedical R&D expenditures and its domestic pharmaceutical market about 40% of the global market. Among the five leading pharmaceutical markets in the European Union (France, Germany, Italy, Spain, and the United Kingdom), Germany ranks the highest with an overall ranking of 15 among the 56 countries analyzed for the study. Italy ranks 18th, **the United Kingdom ranks 24th, Spain 25th, and France 40th. In the case of the UK, Spain, and France, the indicator of high price controls brought down those countries' rankings.** Germany and Italy, which ranked higher, have more moderate price controls, have biologics data exclusivity, and have moderate government contribution to life sciences research of 12.3% (Germany) and 16.6% (Italy), reflecting the percentage of government research dedicated to the life sciences/health.

Wayne **Winegarden**, *(Partner in the economic consulting firm Arduin, Laffer & Moore Econometrics, B.A., M.A. and Ph.D. in Economics from George Mason University),* 10-12-20**17**, "Price Controls Will Reduce Innovation and Health Outcomes," **Forbes**, https://www.forbes.com/sites/econostats/2017/10/12/price-controls-will-reduce-innovation-and-health-outcomes/#7f36381263a6 //AM

While inapplicable to most patients, the minority of patients who take innovative medicines that are still on patent (e.g. the medicines at the frontier of the pharmaceutical market) would be impacted by the proposed price control schemes. And, just like the example of price controls on doctors, the adverse consequences would be, on net, very costly for the U.S. health care system. **The R&D process for**

innovative drugs is lengthy, requires billions of dollars in outlays (**$2.6 billion** as of 2016), **and is fraught with large risks. Price controls make it more difficult for manufacturers to recoup this cost of capital, diminishing the incentives to innovate and bring new medicines to market.** Importantly, the introduction of new drugs has been essential to improving the quality of health care delivered. For example, in December 2013 and October 2014, the FDA approved two new medications to treat Hepatitis C. These medicines were expensive, but they were also cures for a disease that was previously incurable. Of course, by curing the disease, more expensive (and more invasive) surgeries can now be avoided, which will reduce health care expenditures in the long-run even as pharmaceutical expenditures as a share of total health expenditures increased in the short-run. Price controls risk such benefits in the future.

This would be especially bad, as most of this innovation is done by small startup companies, which lack the large profit margins and excess funding that big pharma companies have.

Lori **Ioannou**, 3-28-20**18**, "Big Pharma's billion-dollar scramble to invest in start-ups to fuel innovation," **CNBC**, https://www.cnbc.com/2018/03/26/big-pharmas-scramble-to-invest-in-start-ups-to-fuel-innovation.html //AM

Many are also outsourcing R&D, while reducing product development efforts internally. The trend is accelerating at a rapid pace. **Behind the scenes, pint-size ventures are driving pharma innovation. The majority of drugs approved in recent years originated at smaller outfits— 63 percent of them over the last five years,** according to HBM Partners, a health-care investing firm. The allure is multifaceted. **Small biotech start-ups are more nimble, and many can do research and product development faster.** By investing in a broad portfolio of young ventures, a big drug company can leverage outside scientific talent and cast a wide net in order to gain access to breakthrough discoveries in areas of the company's strategic interest. For investors the sheer market size of the industry cannot be ignored. It's a global market growing at 6.5 percent compounded annually that is expected to reach $1.06 trillion by 2022, HBM forecasts.

Innovation must continue, and this largely happens through biotechnology startups. However, price controls would decrease venture capital investment into this area.

Paul **Howard**, September 20**16**, "HIGHER PRICES, FEWER CHOICES, Why California's Prop. 61 Will Not Bring Drug-Price Relief," **Manhattan Institute**, https://www.manhattan-institute.org/sites/default/files/IB-PH-0916.pdf //AM

Less Investment in California's World-Class Biotech Start-Ups California's ecosystem of leading universities, experienced venture-capital firms, and large life-sciences companies makes it a magnet for venture-capital investment. In 2015, California attracted $4.8 billion in biotech and medical-device venture funding, more than double that of the next highest state, Massachusetts.28 **If America's medicines industry became significantly less profitable—the explicit aim of [price controls]** Prop. 61—**it would weaken financial incentives for supporting entrepreneurship and innovation among** the Golden State's many start-up **biotech companies, which depend on venture funding to develop their technologies. Even the threat of drug-price controls on a large scale** (which could occur if Prop. 61 passed and was emulated by other states or the federal government) **can reduce incentives to invest in drug research and development by depressing expected returns to investors. For instance, firms responded to the specter of drug-price controls in the 1993 Health Security Act by reducing pharmaceutical research and development funding by $1.5 billion.**29 Other researchers suggest that **a 40%–50% reduction in U.S. drug prices** (comparable to the effect of mandating VA prices) **would slash investment in early-stage drug-development efforts by 30%–60%.**30 California's **The**

start-up community—responsible for developing cutting-edge technologies, such as gene splicing,31 that have redefined American medicine**—would bear the brunt of this decline in U.S. investment capital.**

The impact is antibiotic resistant diseases.

Charlotte Hu, 7-21-2018, "Pharmaceutical companies are backing away from a growing threat that could kill 10 million people a year by 2050," Business Insider, https://www.businessinsider.com/major-pharmaceutical-companies-dropping-antibiotic-projects-superbugs-2018-7 //AM

Just two years after **Novartis announced it would** embrace the challenge of searching for cures for life-threatening infections known as superbugs, the drugmaker said last week it would **exit antibacterial and antiviral research. Novartis' retreat follows a growing trend of big pharmaceutical companies** — including AstraZeneca, Sanofi, and Allergan — **that are exiting from this type of research because of a lack of profit.** That leaves Merck, Roche, GlaxoSmithKline, and Pfizer as the remaining pharmaceutical companies with active antibiotic programs, according to Nature Biotechnology. Only 12 antibiotics have been approved since 2000. Ever since the invention of penicillin, antibiotic development has been a treadmill. Patients who took too little or too much antibiotics would evolutionarily select for stronger strains by killing off only the sensitive bacteria. Antibiotics were once a lucrative business before inventing new drugs to catch up with the evolution of resistant strains became exhausting. Dr. Jean Patel, science team lead of antibiotic strategy and coordination unit at the CDC, said a fair number of **active antibiotics used against bacteria actually come from small, startup-sized companies,** that usually later get acquired by big pharma, which provides the infrastructure to complete clinical trials and market the drug. But with increasing numbers of big pharma firms backing out of antibiotic pursuits, it decreases the variety of new drugs that can be brought to market.

2018, "One discovery that changed the world," **University of Adelaide**, https://health.adelaide.edu.au/florey120anniversary/one-discovery-that-changed-the-world //AM

In 1940, Howard Florey's newly created drug cured four infected mice—and changed the course of medical history. **Penicillin, the world's first antibiotic, has since saved an estimated 200 million lives.** Florey, we're proud to say, started his journey at the University of Adelaide, where he continues to inspire generation after generation of dedicated health researchers and students.

Charlotte Hu, 7-21-2018, "Pharmaceutical companies are backing away from a growing threat that could kill 10 million people a year by 2050," Business Insider, https://www.businessinsider.com/major-pharmaceutical-companies-dropping-antibiotic-projects-superbugs-2018-7 //AM

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that can be brought to market. "The costs to develop a new antibiotic drug are no less expensive compared to development of drugs for other therapeutic areas, yet the commercial potential and return on investment for companies developing new antibiotics are significantly lower than drugs to treat chronic conditions such as diabetes or heart disease," said Gary Disbrow, deputy director of the Biomedical Advanced Research and Development Authority, which sits within the U.S. Department of Health and Human Services. **The lack of research** from big pharma companies **is a problem**. **Each year in the US at least 2 million people become infected with antibiotic-resistant bacteria, according to Centers for Disease Control and Prevention, and 23,000 people die each year as a direct result of these infections. It's estimated that as many as 10 million people could die annually from superbugs by 2050 if nothing is done**, according to a report commissioned by the UK.

Contention Two is Developing Countries

Schweitzer 11 Stuart O. Schweitzer [professor in the School of Public Health at the University of California, Los Angeles], 8-2011, "Prices Of Pharmaceuticals In Poor Countries Are Much Lower Than In Wealthy Countries," Health Affairs, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0923 //DF

Three studies report ratios of marginal cost, determined in this manner, to the price of products that are still patented. David Reiffen and Michael Ward "find that the implied ratio of marginal cost to pre-expiry branded prices when there are 11 or more firms is approximately 50 percent." 22(p44) Richard Frank and David Salkever report that "with each additional [generic] entrant there is a fall in the average price of a generic product of between 5.6 percent and 7.2 percent." 23(p88) Accordingly, increasing the number of generic producers from one to eleven would lead to a price reduction of more than 50 percent from the price of the original drug. And Richard Caves and colleagues find that with ten generic drug producers in a particular market, generic prices average fully 70 percent below the original price. 24 PRICES IN THE UNITED STATES AND ELSEWHERE These benchmark figures can be compared with the price data in our study. Exhibit 3 shows that the **average prices for patented drugs in developing countries are less than 20 percent of those in the United States**, while prices in middle-income countries average 32 percent of US prices. These prices are thus below the benchmark estimates of US marginal costs. Although it is possible that marginal costs of pharmaceutical production are lower in developing or middle-income countries than in the United States, the effect of such reduced costs could not be large because most patented drugs are manufactured in industrialized countries. For these drugs, therefore, current prices outside the United States are generally lower than marginal costs. It is more difficult to draw firm conclusions about the fairness of pricing for drugs that are no longer patented (Exhibit 3). Although for some of these products, prices in developing countries approach marginal costs, that is not always the case. For essential drugs, however, it is clear that prices are not higher than marginal costs. There is little indication, therefore, that average drug prices in developing and middle-income countries exceed the standard set by marginal costs.

Michelle **Mello**, 20**18**, "What Makes Ensuring Access to Affordable Prescription Drugs the Hardest Problem in Health Policy?" **Minnesota Law Review**, http://www.minnesotalawreview.org/wp-content/uploads/2018/07/Mello_MLR.pdf //AM

Another perplexing moral problem is that tradeoffs may exist between improving the affordability of prescription drugs for Americans and maintaining their affordability to patients in other countries.53 Branded drug prices in the United States are generally higher than in other countries because most foreign governments have adopted stronger mechanisms than the United States for controlling prices—for example, more consolidated price negotiations or direct price controls.54 **Because we pay so much, pharmaceutical companies may be more willing or able to grant price concessions** elsewhere, including outright donation of critical medications **to low-income countries**. **Actions we take to restrict price**, therefore, **could have unintended**, but real, **effects on drug affordability in less wealthy countries.** This prospect raises the question of what obligations, if any, Americans have to patients in the rest of the world. Some conceptions of global justice hold that members of relatively wealthy societies have a moral obligation to consider the welfare of individuals in poorer countries in making policy decisions. Other views challenge the notion that such duties exist.56 Some even assert that the status quo is unfair: Americans not only pay more for marketed drugs, they shoulder a disproportionate share of the cost of developing those drugs.57 Pharmaceutical R&D is underwritten both by the high prices Americans pay for medicines and the tax dollars we spend on basic-science research to identify promising new molecules.58 Americans have not openly confronted these clashing viewpoints as a polity, but strong measures to reduce the cost of prescription drugs here would make the global-justice dilemma hard to ignore. Further, as with the other moral dilemmas discussed above, the problem has greater salience in the context of prescription drugs than in other areas of health policy. It is true that other health policy decisions we make, such as

how much of federal agencies' budgets to devote to health system capacity building in low-income countries, also affect the healthcare costs that poor countries must bear. However, because **the market for prescription drugs is global but is propped up by high prices in the United States, tamping down drug prices has a zero-sumgame quality that is unique. Squeezing one part of the drug-price balloon may cause it to bulge out in other areas.** In addition to these moral factors, a number of problems in the market for prescription drugs contribute to making drug affordability the hardest problem in health policy. I turn to these issues next.

Nov 20, **2018**, "Global Statistics," **HIV.gov,**
https://www.hiv.gov/hiv-basics/overview/data-and-trends/global-statistics //AM

There were approximately 36.9 million people worldwide living with HIV/AIDS in 2017. Of these, 1.8 million were children (<15 years old). An estimated 1.8 million individuals worldwide became newly infected with HIV in 2017 – about 5,000 new infections per day.

M.J. Pearson, June 2010, "Access to HIV Treatments in Developing Countries Case Summary,"
https://scholarworks.umass.edu/cgi/viewcontent.cgi?article=1024&context=edethicsinscience //AM

Growing awareness in the 1990s that **HIV and AIDS** were **more prevalent in developing countries than in industrialized ones and** that **effective treatments** were **available to only a few patients because of limited government and personal incomes,** transformed HIV/AIDS advocacy efforts. Pressuring governments and pharmaceutical companies to ensure provision of treatment to larger numbers of HIV-infected persons (often called "HIV-positive persons" or "persons living with HIV") became a priority. **The high prices of HIV medications were quickly identified as a major barrier to access**, and became the subject of a significant ethical contention, which continues to this day. After providing background on the treatment of HIV infection, this case will summarize the key features of the ethical contention.

World Health Organization, "WHO,"
http://www.who.int/hiv/mediacentre/news/high-quality-arv-reduced-price/en/ //AM

New York – **A breakthrough pricing agreement** has been announced which **will accelerate the availability of the first affordable, generic, single-pill HIV treatment regimen** containing dolutegravir (DTG) **to public sector purchasers in low- and middle-income countries** (LMICs) **at around US$75 per person, per year.** The agreement is expected to accelerate treatment rollout as part of global efforts to reach all 36.7 million people living with HIV with high-quality antiretroviral therapy. UNAIDS estimates that in 2016, just over half (19.5 million) of all people living with HIV had access to the lifesaving medicines.

Nov 20, **2018**, "Global Statistics," **HIV.gov,**
https://www.hiv.gov/hiv-basics/overview/data-and-trends/global-statistics //AM

Approximately 75% of people living with HIV globally were aware of their HIV status in 2017. The remaining 25% (over 9 million people) still need access to HIV testing services. HIV testing is an essential gateway to HIV prevention, treatment, care and support services. **In 2017, 21.7 million people living with HIV (59%) were accessing antiretroviral therapy (ART) globally, an increase of 2.3 million since 2016 and up from 8 million in 2010. HIV treatment access is key to the global effort to end AIDS as a public health threat.** People living with HIV who are aware of their status, take ART daily as prescribed, and get and keep an undetectable viral load can live long, healthy lives. There is also a major prevention benefit. People living with HIV who adhere to HIV treatment and get and keep an undetectable viral load have effectively no risk of sexually transmitting HIV to their HIV-negative partners. AIDS-related deaths have been reduced by more than 51% since the peak in 2004. **In 2017, 940 000 people died from AIDS-related illnesses worldwide, compared to 1.4 million in 2010 and 1.9 million in 2004.**

The vast majority of people living with HIV are in low- and middle-income countries. In 2017, there were 19.6 million people living with HIV (53%) in eastern and southern Africa, 6.1 million (16%) in western and central Africa, 5.2 million (14%) in Asia and the Pacific, and 2.2 million (6%) in Western and Central Europe and North America. Despite advances in our scientific understanding of HIV and its prevention and treatment as well as years of significant effort by the global health community and leading government and civil society organizations, too many people living with HIV or at risk for HIV still do not have access to prevention, care, and treatment, and there is still no cure. However, effective treatment with antiretroviral drugs can control the virus so that people with HIV can enjoy healthy lives and reduce the risk of transmitting the virus to others.

Low prices are needed to ensure people in poor countries can afford the medicines

Wagner 04 Judith L. Wagner [Institute of Medicine], 2004, "INTERNATIONAL DIFFERENCES IN DRUG PRICES," Annual Review of Public Health, https://www.annualreviews.org/doi/pdf/10.1146/annurev.publhealth.25.101802.123042 //DF

As discussed above, manufacturers of single-source drugs should be willing to charge lower prices in low-income countries. Although some single-source drugs have been made available for free or at nominal charge to developing countries with high endemic rates of diseases such as HIV/AIDS and tuberculosis (15), manufacturers of single-source drugs are reluctant to offer vastly lower prices across the wider spectrum of drugs. **For countries with extreme rates of poverty, anything but very low prices would render single-source drugs unavailable to all but the few wealthy residents**. The principal impediments to low prices are the fears of the drug companies that a resale market would develop across national borders from low-income countries to high-income countries or that political pressures would develop in high-income countries to demand the lower prices given to the low-income countries (20). These fears may be justified given the history in the United States of consumer groups and policy makers questioning the need for high markups on production costs (27) and calling for relaxation of rules governing cross-border trade in pharmaceuticals (24, 28).