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Free Trade Against Free Riders?

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Kevin Outterson[1]

For years I've wanted to stand up in an airplane and ask the passengers to tell everyone what they paid for their ticket. If I didn't get hauled off by airport security, we'd find out that everyone pays remarkably different prices for the same service. Economists call this *price discrimination*, and generally consider it beneficial, despite its ominous overtones. Companies make more money by segmenting their markets and charging people what the market will bear. Drug companies are no exception.

The pharmaceutical industry fully embraces price discrimination. Spend some time on the Internet website for the new US Medicare drug card and you will discover great variation in prices. Outside of Medicare, the uninsured historically paid the highest prices for prescription drugs; veterans and patients at public health clinics received very significant discounts. HMOs and other purchasers pay less than the uninsured, but more than veterans. Everyone receives a different price. Nor is this likely to change anytime soon. In the recent Medicare Modernization Act, PhRMA asked for a study on an extreme form of price discrimination known as Ramsey Optimal Pricing, seeking to extend its reach under US law.

Pharmaceutical price discrimination is especially evident once you leave the US and look abroad. Patented Canadian drugs are famously cheaper, but Australian drugs are 40% cheaper still. In many AIDS programs in Africa, drugs that cost $10,000 a year in the US are available for $360 per year or less. In the latter case, price discrimination operates to make drugs available to desperately poor populations, combining good business practices with humanitarian goals.

That's well and good for sub-Saharan Africa, but what about Canada and Australia? Why should they get lower prices than the US? PhRMA complain that price controls outside of the US artificially depress the prices, allowing other rich countries to 'free ride' on American innovation.

In response, the US recently insisted on provisions in the Australia-US Free Trade Agreement designed to increase drug prices in Australia and to prevent the sale of cheap Australian drugs in the US. Similar provisions are promised for a raft of pending and future trade agreements, and a new drug price czar has been appointed in the USTR. Attacking free riders makes for a great sound bite, but what are the objections to this trade strategy?

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Hypocrisy is always a good place to start. Some of those evil 'free riders' are right here at home, including Medicaid, the Veteran's Administration and the US Public Health Service. Canadian prices are broadly similar to the US Federal Supply Schedule. Some Medicaid rebates and the US Public Health Service's 340b program get better deals than Australia on some drugs. Before we pick up stones, we should check the glazing in our own houses.

Attacking free riders reminds me of the apocryphal children who killed their parents and then plead for leniency because they were orphans. The pharmaceutical industry created today's price discrimination system, inevitably attracting free riders. Think back to the airplane flight. Some frequent flyers are literally flying free. Others bought deeply discounted fares. The folks up in first class (and the last-minute business travelers) are shouldering a disproportionate share of the costs. And yet, we accept this as good business practice. Price discrimination and free riding can be two sides of the same coin.

PhRMA's free riders might actually be smart shoppers. Price discrimination says nothing about the overall level of prices. Put another way, if Australian prices are raised, where is the guarantee that American prices will be reduced? Perhaps the trade crusade against the scourge of low-priced Australian drugs is misplaced, and it is American prices which are out of line. To answer this question properly requires PhRMA transparency, work which should be completed before the US implements a trade strategy which offends the best trading partners by insisting on raising their domestic drug prices.

Societies make different sovereign choices on access and prices. In the US, prices are higher and millions of people lack access to meaningful drug benefits. In most other OECD countries, prices are lower, but drug companies still make good profits. (In a recent Tax Court filing, GlaxoSmithKline argues that most of its profits are in Europe, not the US). They make up for the lower prices through higher volumes since drug benefits are nearly universal. It may be unfair to label such countries as free riders.

Before racing to trade agreements to solve pharmaceutical pricing problems, the US should remember that it doesn't always win trade disputes. (The US recently lost cases on steel and taxes). If the US places drug pricing on the international trade agenda, they may be surprised one day to find themselves on the losing side of a dispute on how Medicare, Medicaid or the VA purchases drugs. The Australia-US Free Trade Agreement implicates Medicare Part B purchases (a modest category of drugs administered directly by physicians), and some argue it will cover the new Medicare Part D benefit as well (all outpatient prescription drugs, a $600 billion benefit over the next 10 years). Now perhaps we can understand why Australians are so upset about US demands that they amend their Pharmaceutical Benefits Scheme.

Patented drugs are a unique category of property. If one doesn't like an airline's prices, choose a different carrier or mode of transportation, or stay home. But if you need a life-saving drug, and can't afford it, the patent system has played a cruel trick, akin to a starving person being invited to watch a lavish dinner party. The US should not be using trade agreements to raise drug prices and hinder access.