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THE DRUG REIMPORTATION BAN: A LESS-THAN-PERFECT SOLUTION THAT BEATS ALL THE REST

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"If [reimportation] succeeds, American consumers would get the short-term windfall of lower prices, but they would end up unnecessarily suffering and living shorter lives—because promising new therapies would be delayed or not even developed."

From an open letter to Congress signed by
Milton Friedman and over 100 other economists[1]

SUMMARY

The ban on reimporting pharmaceuticals appears, at first, to violate our national commitment to free trade. Several key factors, however, make this a unique controversy: pharmaceutical patent rights face serious threats internationally, and the pharmaceutical industry's ability to defend these rights is itself hampered by domestic law. Under these circumstances, the ban essentially functions as a government substitute for reimportation limits that, in a perfect world, would be negotiated by drug companies themselves.

To an extent, similar problems are faced by other industries that have steeply declining marginal costs. To the extent that the pharmaceutical industry can adapt the business techniques of such industries, it may be able to alleviate the problems posed by reimportation.

Nonetheless, in the short term there is one unmistakable fact—when we reimport drugs from foreign countries, we are actually importing their price controls. Doing so will produce the problems that price controls always produce—the destruction of future productivity and innovation. This effect is always harmful, but in the field of medicine that harm would be incomparable.

I. REIMPORTATION: OF DRUGS, OR OF PRICE CONTROLS?

For millions of Americans, drug reimportation appears to hold the tantalizing promise of relief from high pharmaceutical costs. The alleged ease of legalizing reimportation adds to its attractiveness; all that is supposedly necessary would be a simple change in the law, legalizing an activity in which thousands of Americans already engage.

In this sense, the drug reimportation debate is similar to many other price control debates. Price controls have largely disappeared from this country, but they are a way of life in totalitarian countries and they are frequently imposed in many developing and post-Communist nations. Price controls offer the promise of bargains for consumers, while their cost is borne only by "bad guys". In the case of rent control, the bad guys are greedy landlords; in the case of bread, the bad guys are price-gouging bakers; in the case of medicines, the bad guys are profiteering drug companies.

Yet price controls are, historically, a dismal failure; in the short-term they may produce a drop in prices, but they also destroy the incentives to produce more goods. Under rent control, housing stocks deteriorate; under price controls, bread shortages proliferate. A survey of economists 20 years ago demonstrated that the destructive effect of price controls is more widely recognized by economists than is practically any other regulatory effect. As a Swedish economist once noted, "rent control appears to be the most efficient technique presently known to destroy a city—except for bombing."

But is drug reimportation really a form of price control? Many supporters of legalized reimportation either expressly favor price controls or are unconcerned about their long-term effects—in their view, the fact that drugs are less expensive in other countries is all that matters.

For advocates of free markets, on the other hand, the issue is more complex. Some free marketers view the reimportation ban as preposterous—if drugs are legally available outside this country at bargain prices, then why should Americans be barred from obtaining them? Such a bar is nothing more, in their view, than an unjustified restriction on free trade. They do acknowledge that American drug manufacturers may contractually seek to limit the reimportation into this country of their products, but they question why the federal government should be responsible for effectively enforcing such contracts through a trade ban.

In fact, these free marketers are correct. Such a ban would be preposterous—*were it not for three facts that are unique to this controversy:*

1) what is at issue here are patent rights—a limited exception to free trade that is expressly provided for in the Constitution;

2) international treaties have severely weakened the ability of drugmakers to negotiate with foreign governments, because they run the risk of having their patents unilaterally broken; and

3) this problem, and the related issue of dealing with foreign governments as monopsony drug purchasers, could be alleviated by American drugmakers banding together to negotiate. However, domestic antitrust laws prohibit such industry cooperation.

As these factors indicate, drug reimportation cannot be straightforwardly analyzed simply in free market terms. If drug companies could freely negotiate contracts, their agreements with foreign distributors would restrict reimportation in order to preserve their ability to recover the huge research and development costs necessary for launching new drugs. In effect, the reimportation ban functions as a government-assisted substitute for that missing contractual freedom. It may be an imperfect substitute, but the very concept of government-granted patents is also imperfect.

In neither case is imperfection a ground for elimination. Optimal policy decisions, at least in the short-term, occasionally call for second-best solutions. In fact, this approach has actually been formalized by several economists into what is known as "the theory of the second best".[2] Under this theory, piecemeal reforms to correct a regulatory distortion in one market for a product may actually be harmful if there are distortions present in other markets for that product. The "theory of the second best" as applied to the drug reimportation debate suggests that removing the reimportation ban may harm overall consumer welfare in light of how patent rights, international treaties and antitrust laws have distorted the market.

When one is deep within enemy territory, the direct dash to the border is rarely the best strategy. That adage is even truer in an industry as dependent on patents, and as pervasively distorted by other government regulations, as the pharmaceutical sector. This paper argues that in today's world of pervasive regulation, it is unlikely that repeal will advance liberty. Instead, dismantling the laws that support the pharmaceutical industry's current business model pose severe risks. The paper explores a range of alternative financial recovery options the industry should consider if current strategies for ensuring profits prove no longer viable. There must be commensurate industry deregulation if there is to be a lessening of government regulatory protections. Until and unless we take steps to free the industry and allow it to attempt these less-intrusive cost recovery measures, we should not destroy its current business model.

II. PROBLEMS FACING THE PHARMACEUTICAL INDUSTRY

A. Partial Economic Liberalization

Recent history has demonstrated that economic liberalization is not always a straightforward matter. Our experience with electricity and telephone "deregulation" demonstrates that partial liberalization can create downstream problems that threaten or even reverse the hoped-for consumer benefits. The most serious threat facing the pharmaceutical industry is that current policies are all too likely to transform the private

pharmaceutical industry into a regulated public utility, drastically reducing the rate of medical innovation.

Of course, most importation advocates aren't concerned about economic liberalization at all. As with most price control advocates, they believe that this move will lower consumer costs and pay little attention to the impacts of such rules on future investment. Their goal is made obvious by their statements; everything is framed in terms of "eliminating the unfairness of the current pricing system." Few advocate requiring (relatively) wealthy Canadians and Europeans to pay more, indeed, some laws make it illegal. The Dorgan/Stabenow "Pharmaceutical Market Access and Drug Safety Act", S. 2328, for example, expressly bars drug companies raising prices or restricting supplies to foreign distributors!

B. The Financing Problem – Declining Marginal Costs

"If you doubt the power of the 'price should equal marginal cost mantra',
or the moral component that has been infused into it,
check out speeches by officials of the Antitrust Division …."
-- James V. DeLong, "Marginalized", July 29, 2003[3]

More than most sectors of the economy, the pharmaceutical industry has long been characterized by its declining marginal cost structure. There is a drug company adage that, for any new medicine, the first pill costs $800 million while every pill after that costs pennies. In a totally unconstrained market—unconstrained, that is, by enforceable patent rights--competitive forces would drive prices toward marginal costs, to levels below those needed for financial viability. It is far from clear that it will be possible to retain high rates of innovation if pharmaceutical products become commodity products.

The cost structure of the pharmaceutical sector is, in part, an artifact of the pervasive regulatory world in which it exists. That declining cost structure is made more severe by the pervasive role of governments around the world in the health industry generally. Note that many purchasers of drugs are political rather than private entities. And governments can and do exert coercive power over this sector. Governments can and do control licenses, terms of sale, approvals, advertising policies and other critical aspects of the industry. Canada and other socialized health care systems (including U.S. federal and state health programs including Medicare and the Veteran's Administration) have used those powers to force global pharmaceutical companies into providing them drugs at deep discounts. Still, the U.S. retains remnants of a private health system. United States consumers are the major lifeline holding afloat the pharmaceutical industries. The result, however, is that wealthier consumers in the U.S. bear a disproportionate share of the overhead costs of the pharmaceutical industry.

The directional solutions to this problem are clear: free the industry from political coercion, reduce the burden of Food and Drug Administration (FDA) approval and other fixed costs, curb frivolous lawsuits and other tort abuses, and permit companies to coordinate their selling practices at home and abroad. The Department of Justice (DOJ)

should provide antitrust exemptions to allow drug companies to challenge the monopsony power now exerted on them by socialized medical systems. DOJ should also immunize the drug industry in its efforts to find ways to distribute drugs in LDCs in ways that do not destroy the industry's ability to recover costs from wealthier consumers.

C. Cannibalizing Past Advancements

> **"***The next phase in what can be called …'a free lunch of drugs' is the effort to legalize the importation of drugs from countries that have British-style [health] systems …."*
>
> James Pinkerton, "Pushme-Pullyu Socialism", Aug. 20, 2003[4]

Proponents of legalizing reimportation argue that it is possible to exploit past research efforts of the drug industry for the benefit of current drug consumers. In a sense, that is always possible; following the disastrous path of rent control in New York City, for example, we could reduce the prices paid by this generation to minimal levels but that would threaten the future supply of health-enhancing products. But such a move would be tragic. AIDS will not be the last plague to torment mankind. The phenomenon of aging alone confronts us with many ailments uncommon in earlier days, ailments which only an accelerating rate of medical innovation can address. To weaken the incentives for research is to weaken our ability to gain future health benefits.

The high profits associated with providing breakthrough medical products encourage high levels of investment in private biomedical research. Heart valves and stents, statins and anti-depressants are but some of the innovations that this has produced. Some argue that this all can be achieved by government-funded research. That hope, however, has little support in the empirical world. The Postal Service, with its mandate of economical, universal service, is a prime example of technological stagnation. NASA, whose statutory mission places it on the very frontiers of innovation, is increasingly recognized as a purveyor of overpriced, unimaginative and unreliable technology—a fact cogently demonstrated by this past summer's private space launch successes.

Society gains much from "high" drug prices. A recent Yale study found that the average American lifespan is increased by nearly three weeks for *every* new drug that reaches the pharmacy shelf. As a result, millions of Americans are now alive or are living more functional lives. Pharmaceutical interventions not only address problems that could not be addressed before, such as depression, but also are generally more cost effective than surgical alternatives. Increased drug expenditures have to a large extent *lowered* overall health care costs, especially with regards to those therapeutic areas utilizing antidepressants and anti-psychotics. And as our society ages, our need for biomedical innovations will become ever more valuable.

These social benefits cannot be overestimated; by some accounts, health gains overall (from drug and other advances) actually equal our total economic growth. If this process is stopped, the engine of health progress will soon grind to a halt.

In some areas of the world, that engine *has* been stopped. European firms are investing less and less in R&D. The European firms that twenty years ago dominated R&D are now investing less than their American competitors.

The challenge therefore is to find ways to strengthen the ability of free markets to provide medical assistance via the technologies of the past, while also providing economic awards to those who provide solutions for the problems of tomorrow. Focusing on ways in which declining cost industries have solved this problem elsewhere is an important part of that solution.

III. COLLAPSE OF THE TRADITIONAL PHARMACEUTICAL BUSINESS MODEL

> *"[A]gainst our strong libertarian instincts we create the patent monopoly as a spur to production, and in no area is the case for patent protection stronger than it is with pharmaceutical products."*
>
> Richard A. Epstein, "Once More into the Breach", Aug. 18, 2003[5]

For decades, the pharmaceutical industry has relied on two primary methods for pricing its products:

- Intellectual property rules which grant the innovator a temporary monopoly in her creation and
- Diversity or value-based pricing, which seeks to recover larger sums from those finding greater value in the products and/or having a greater ability to pay.

These methods have served the industry well in the past. Today, however, both are under assault because of the lack of understanding of the marginal cost problem and the difficulty of sustaining these approaches in a global politicized economy.

In the past, the U.S. government has assisted both of these techniques. America has banned importation of drugs, making it easier to maintain diversity pricing. It has also fought vigorously (some would argue too vigorously) to impose U.S. intellectual property laws throughout the world. However, politics at home and abroad is weakening political support for such an approach.

In part, this loss of support reflects extent to which pharmaceutical accomplishments are hidden from public view by America's third-party payer system. New and costly drugs address conditions once deemed untreatable, and are reflected in higher out-of-pocket costs for patients. These drugs replace even more costly medical alternatives, such as surgery, but that cost reduction is not publicly apparent. (Note that, unlike pharmaceuticals, surgical interventions cannot be imported. Thus, subsidized surgical alternatives in Canada or Europe do not undercut U.S. surgery pricing policies. Moreover, the cost of a surgical procedure does not decline sharply as the number of

procedures undertaken increases. Thus, drugs are unique in their vulnerability to political exploitation over pricing.)

A. Parallel Trade

In a global economy, it is hard to prevent a product from being purchased in low cost nations and then resold to higher priced nations. While contractual restrictions and trade barriers may "leak," populist politicians (and poorly informed analysts) promote such leakage in the desire to become "consumer champions." The losses from diminished innovation are unlikely to be blamed on them.

"Conventional" reimportation has thus always been a concern. But as discussed below, for the pharmaceutical industry its nature has been hugely magnified by patent and pricing issues. Moreover, these are far from the only problems facing the industry.

B. Intellectual Property and Diversity Pricing

Intellectual property rules vary widely around the world, as do views on the fairness of short-term monopoly privileges. Disagreement is especially severe when the lack of such products is perceived as killing people. But in fact, most nations that experience high death rates suffer not from intellectual property rules, but from a lack of distribution system to bring these drugs effectively to those in need. Nonetheless, rules allowing drug companies to charge high prices in poor countries have been seen as immoral.

The problems of designing diversity pricing policies in a global economy have not been well understood – nor has their value been well explained. Both diversity pricing and intellectual property rights were much more easily enforced in the pre-internet world where markets were geographically isolated and where information on drug prices was difficult to acquire. In today's global cyber-economy, maintaining diversity pricing has become much more difficult, as anyone in the airline industry knows only too well. When the product can be economically transferred from one jurisdiction to another, when knowledge of the prices paid elsewhere becomes readily available, diversity pricing is much harder to maintain. Low-priced sales in one jurisdiction lead to political pressures to universalize these lower prices elsewhere.

In part, the current crisis is the fault of the pharmaceutical industry itself. It did not understand the ways in which globalization, reduced information costs, and the growing importance of fiscally-stressed government purchasing agents would make it increasingly difficult to maintain its historic financial cost recovery business model. As a result, it now finds itself relying far too heavily on the special protections afforded intellectual property in wealthier countries, but being unable to enforce these rules in LDCs. It also gave way too quickly to political pressures to lower drug costs to governmental agencies here and abroad without thinking through how those discount policies would encourage further political predation. Finally, it underestimated the extent to which the internet would require greater legitimization of diversity pricing and make it harder to enforce trade barriers.

The undue reliance on intellectual property led the drug industry to successfully advocate the World Trade Organization for intellectual property protections during the Uruguay Round. The result was the formation of a special section on Trade-Related Aspects of Intellectual Property Rights (TRIPS). The TRIPS agreement establishes minimum intellectual property standards and requires member nations to modify their national regulations to conform to the rules of the Agreement. It provides patent protection to pharmaceutical product and process inventions.

Many now question this inclusion in an otherwise win/win trade agreement. It resulted in little benefit for the least developed countries, since patent and copyright royalties are largely earned by developing nations.

The TRIPS accord soon came under attack in Africa, where pharmaceutical sales were relatively unimportant. AIDS was ravishing the continent. High cost drugs had been developed for wealthier nations; yet, those costs made these drugs unavailable to Africans. However, that problem cannot be blamed entirely, or even in large part, on the declining marginal cost issue. Even the marginal cost of producing these drugs exceeded the price that could be borne in areas where annual incomes fell below a dollar a day. Even had such drugs been available for free, the primitive systems for storing, prescribing and distributing them would have reduced their value. The willingness of the drug companies to lower prices could not "solve" the problem and threatened to undermine pricing policies in Europe and elsewhere.

The resulting impasse was blamed on TRIPS, and the demonization of the drug industry followed. This was disastrous; the companies were seen as placing profits ahead of life and were forced to retreat. The result was the weakening of TRIPS at the World Trade Organization meeting in Doha, and the decision to allow countries to waive intellectual property rights and use compulsory licensing for domestic pharmaceutical suppliers during "health emergencies." That retreat soon led other developing countries (especially those capable of producing modern drugs, such as India and Brazil) to demand the right to market generic versions of AIDS drugs to these poorer countries. Poor nations, in turn, have little ability to police the re-exportation of these drugs to richer nations. The result has been the weakening, if not the eventual destruction, of the TRIPS framework.

In seeking to negotiate with government purchasing agents today, the pharmaceutical industry faces major problems stemming from these moves. A firm's insistent efforts to force a country to absorb higher costs may well lead to the seizure of the firm's intellectual property. Worse yet, the generic product produced in that country may then find its way into the United States and elsewhere.

C. The Airline Analogy

Consider the airline industry. Traditionally, airlines charged differential rates based (in part) on the value received by their customers or their ability to pay. Airlines developed elaborate yield-management systems to track the demand characteristics of various

customers over different origin-destination pairs. Business and last minute travelers pay higher fares than the casual economy traveler. Yield management both allows greater recovery from business travelers (enforced by Saturday night stay-over requirements and other restrictions) and thus made it possible to also offer lower economy fares to discretionary (high elasticity of demand) travelers.

These restrictions are made possible by the inability of a service commodity to be transferred from one class of user to another. Airline tickets are useable only by the name-purchaser of the ticket. Current airport security rules make that policy easy to enforce. Were laws to require airline tickets to be transferable (the rough equivalent of the importation repeal), the current airline financial model would soon collapse.

It is possible, of course, that other models would emerge – the newly emergent low cost carriers rely on lower fares which are made possible by their lower cost structure. That lower cost structure, however, may reflect more reasonable labor wage and work rules and newer and standardized capital stock. Whether these airlines will find diversity pricing necessary as they mature is unclear. Whether similar cost reductions are possible in the pharmaceutical industry remains even more unclear. Clearly, major political reforms would be necessary to reduce FDA approval costs and to permit "copycat" and other cost-reducing products to enter the market.

D. Government "Discounts"

The pharmaceutical industry sells much of its products to government entities. These government purchasers are not market actors; they can and do wield the coercive power of the state (withholding licenses, imposing punitive regulations or taxes, preempting patent protections, giving preferential treatment to national firms) to gain non-cost based price reductions. There is a major power imbalance between the pharmaceutical companies and their monopsony socialized health-care customers.

This problem is domestic as well as foreign. The Veteran's Administration, the nation's health care system for former military personnel, uses its coercive powers to force the drug companies to extend volume discounts for *non*-volume transactions. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173), the Department of Health and Human Services is barred from directly negotiating price reductions. There is, of course, a significant difference between selling one million doses of a drug to one purchasing agent, and selling to one million consumers one dose each of a drug purchased by a government agency. State agencies have used that same approach to force similar non-cost based discounts to lower pharmaceutical costs. But as the recent flu vaccine crisis demonstrates, the resulting razor-thin profit margins may in fact jeopardize public health in the long-term.

These cost-containment strategies may contain costs, but they are not based on any actual lowering of costs; their actual basis is government power.

E. Why Hasn't the Pharmaceutical Sector Responded to this Crisis?

Why haven't the drug companies been more aggressive in insisting on reasonable cost recovery policies in Canada and Europe? Why have they been so passive in accepting pricing policies that leave the burden of overhead cost recovery to U.S. consumers? In part, this is a coordination problem. Some drug companies will benefit from some regulations – compulsory licensing will benefit firms whose new drug options have not panned out, for example. Generic drug manufacturers have long been at war with the innovating firms. But, increasingly, some within industry have given up. They see no hope of protecting shareholder value in today's anti-business climate and are willing to become even more highly regulated firms – public utilities in effect. After all, the traditional public utility model was "kind" to the regulated parties. Firms were able to negotiate reasonable rates of return, ensuring modest but more secure dividends for their shareholders. Unfortunately, history suggests that rates of technological improvement are low in regulated industries. Risk taking is not encouraged when profits are held down to "reasonable rates." Is it wise to weaken innovation in this most promising field?

Another factor is that U.S. antitrust regulatory laws inhibit cooperative selling arrangements. Dealing with a monopsonist would be easier if the drug companies were able to coordinate their selling policies and to flex some off-setting market power. A positive step would be to grant antitrust immunity to the drug industry in its sales to government entities.

III. ALTERNATIVE COST RECOVERY STRATEGIES

There are other ways of maintaining financial viability for declining cost industries. Possible strategies include the following:

- **Downstream integration** – for example, if the product is dispersed only by the manufacturer in controlled outlets, as in the case of software upgrades. In theory, drug companies could own their own pharmacies, just as the movie companies own theaters. Such an arrangement allows for closer contact with and feedback from the consumer, which can result in better product differentiation.

- **Controls on sales to levels thought suitable for the designated client** (for example, prescriptions which provide a supply suitable only for the one individual for a limited time). This approach might be applied to the distribution outlets in countries where prices are rationally set at lower levels to limit their export to higher cost regions.

- **Contractual terms that preclude the resale** of the product to others, as is frequently done for capital equipment sales and other proprietary products.

- **Market segmentation:** Seeking to establish differential rules for different regions.

- **Diversity Pricing:** These include strategies for ensuring that wealthier customers pay higher prices than do the poor. Upstream manufacturers cannot do this directly since their distributors will sell to different income groups; however, it might be possible to provide coupons selectively or mail-back coupons (means tested) to resolve this problem. There are many ways of allowing price discounting that are less harmful to the future of health in America. [see Danzon paper as way to differentiate b/w poor/rich customers; use of secret rebates as a partial solution].

- **Selective withdrawal from markets:** Markets that are hard to fence may simply not be attractive to marginal cost sectors. Few first run movies are sold to mainstream television channels – the risks of these products being copied and losing revenue are viewed as excessive.

- **Time phasing**: Hard bound books are generally released several months before the lower cost paperbound books are released. The customer whose time preference justifies the earlier purchase will normally pay more.

- **Supplier Co-ops to Coordinate Selling Policy**: Firms selling into specialized markets where monopsony power drives down prices may seek to coordinate their selling policy to prevent such leakage. As noted earlier, extensive coordination is now illegal under most nations' antitrust regulations. In the U.S., Section 2(f) of the Clayton Act, as amended by the Robinson-Patman Act of 1936, makes it unlawful "knowingly to *induce* or receive a discrimination in price" when that price difference can't be "cost justified." Recognizing that coordination does indeed have economic benefits, the FTC and the Antitrust Division of the DOJ have attempted to provide some legal clarity through its "Antitrust Guidelines for Collaborations Among Competitors." The FTC looked at the issue of coordinated sales in its Workshop On Competition Policy in the World of B2B Electronic Marketplaces in June 2000.

- **Pre-purchase Arrangements**: Buyers could order drugs in advance at a fixed price, which would allow risk sharing to occur for the development of new drugs.

- **Reducing the fixed costs of production** by sharing production costs. In the airline industry, for example, some smaller communities have elected to make lump sum payments to an airline willing to provide service. Similarly, nations or disease groups might provide financial support to reduce the costs of discovery and approval.

- **Tort reform** would also reduce the costs (via a reduced risk premium) for drug introductions. Tort liability is not a big cost factor today, although it is certainly escalating.

- **Reducing FDA Costs and Delays:** FDA approval costs are critical; in the words of Milton Friedman, "the real issue … is the FDA, which has made the costs of approving a drug intolerably high."[6] Very few other business sectors face costs of hundreds of millions of dollars and years of time to gain approval for a new product. Imagine if every release of Windows entailed government oversight of testing to determine the risks of viral infection and to ensure effectiveness. Would Bill Gates have even entered this field?

  FDA reforms which reduced drug development and approval times would lower innovation costs. They would also extend the usable patent life over which those costs might be recouped. As a result, the steep slope of the declining marginal cost problem would be diminished.

- **Encourage "Smarter" Shopping:** Government might encourage consumer education efforts based on the wide variation in the prices of most drugs in most communities. This might be coupled with further moves toward medical saving accounts, which provide far more incentive for consumers to consider costs than the dominant third party insurance schemes now in place.

- **Help Drug Companies Enforce Sale Limitation Contracts:** Some proponents of importation claim they wish only to encourage the drug companies to shift some overhead costs to the purchasers in other nations. If so, then they should urge that the USTR and the Department of Commerce champion this policy in trade and economic discussions. Certainly, America does itself no service by subsidizing socialist health care systems around the world.

- **Extend Orphan Drug Act to Developing World Diseases:** Many drugs critical to a healthier world are non-economic under current FDA rules. Drugs valuable to small or poor populations may not justify the costs of gaining FDA approval. The Orphan Drug Act works fairly well at addressing this problem for some US diseases. The underlying concept should be expanded to liberalize approval of drugs most valuable to poorer nations.

These extended options have not been used widely in the pharmaceutical industry. Yet, in today's global economy where knowledge of prices paid elsewhere is widely available and where health care purchases are increasingly financed by powerful governmental agencies, the stability of existing drug financial recovery model is collapsing. We need affordable access to existing drugs and incentives for R&D to develop new drugs. Reconciling these objectives requires price diversity, which requires the separability of markets. A serious review of the broad array of alternative cost recovery measures – and the steps necessary to make them viable – is overdue.

[1] "Milton Friedman and Many Others on the Consequences of Price Controls", Tech Central Station, Nov. 20, 2003, http://www.techcentralstation.com/112003C.html

[2] .See Richard Lipsey and Kelvin Lancaster, "The General Theory of Second Best", *The Review of Economic Studies* (1957). For discussion, see http://internationalecon.com/v1.0/ch100/100c030.html

[3] http://www.techcentralstation.com/072903D.html

[4] http://www.techcentralstation.com/082003C.html

[5] http://www.techcentralstation.com/081803A.html

[6] "Milton Friedman and the Reimportation Debate", Tech Central Station, Feb. 2, 2004, http://www.techcentralstation.com/020204D.html