Gerard Anderson – Professor, Johns Hopkins University Bloomberg School of Public Health, USA

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Dr Gerard Anderson of Johns Hopkins University Bloomberg School of Public Health critiques the US response to the COVID-19 pandemic, before explaining how access and affordability in the US can be improved, and his outlook on the future of American public health.

Gerard, on a topical note, could you start with a few comments on how the United States has handled the COVID-19 pandemic?

We started way too slowly. We had warnings as early as November or December 2019 that the COVID-19 problem was serious and we did virtually nothing. We started responding actively in March or April, in many cases, and we have been trying to play catch up ever since. We have had way more deaths than any European country, even taking into account our larger population, and more deaths than China. To some extent, we are the poster child for how *not* to respond with COVID-19.

Part of this has to do with our public health infrastructure. Whereas in most European countries where the national or federal government is the leading entity with full responsibility for healthcare, in the US, each of the 50 State Governors hold responsibility for healthcare in their own states so they do not have the same type of power. Also, in general, we do not have a very strong public health infrastructure vis-à-vis other industrialized countries. We tend to try to solve the

problem after its occurrence as opposed to preventing the problem. For instance, we have developed a lot of work on pandemics in the past. But before COVID-19, we have not had a pandemic for almost ten years and as a result, we stopped investing in pandemic research and related public health activities. Therefore, when this occurred, we were behind most other industrialized countries.

This year marks ten years since the Affordable Care Act (ACA) was introduced. How do you assess its reception in the USA?

The ACA expanded health coverage quite dramatically and this was very important for the COVID-19 pandemic. Prior to the ACA, around 15-20 percent of Americans lacked health insurance coverage. That figure is now down to less than 10 percent, which means that the majority of the population would not be afraid to get tested for COVID-19 and receive treatment if necessary. For the five to 10 percent of Americans without health insurance, financial concerns might prevent them from accessing diagnosis and care, which increases the likelihood of the disease spreading further. The ACA expanded coverage quite dramatically and this increased access to treatments for COVID-19.

In terms of the acceptance of the ACA, the Democrats and Independents are generally pleased while the Republicans still tend to oppose the legislation. But generally, they are slowly coming around to the idea. Five years ago, I would have said they are totally opposed but many of the Republicans have seen the benefits and the acceptance is growing gradually. The US is typically reluctant to adopt new social programs and I would say it typically takes Americans 10-15 years to accept them.

From our conversations with other stakeholders in the US, access and affordability are critical issues in the US. Why are drug prices in the US so high?

I wrote a paper called ‘It’s the Prices, Stupid: why the United States is so different from other countries.’ It was published in the journal *Health Affairs* in 2003. The reason why the US spends more on health care than any other OECD country without providing more services is very simple: higher prices of goods and services. In 2019, I rewrote the paper with new data and found exactly the same situation. My colleagues and I also wrote another paper comparing US prices for branded drugs to prices in other industrialized countries. We found that on average, they were three to four

times higher. It does vary dramatically from drug to drug: some drug prices were 80 times higher in the US and some were only 30 percent higher, but the average was three to four times higher. I would emphasize here that I am talking about industrialized countries like many European economies, Japan and Australia, whose *per capita* incomes are pretty close to that of the US I do not think Americans should be paying three to four times more for drugs than our counterparts in other industrialized countries.

A big reason for this price difference is that in the US, everyone negotiates independently. We have around five large private insurers, the Medicaid program for the economically disadvantaged, and the Medicare program, which has around 300 entities negotiating on its behalf, whereas in most European countries, you have a single purchaser, which is the government. In the US, the buyers lack the economic clout, which gives a lot of power to the sellers, in this case, the pharma industry.

As a result of this fragmentation, it is not clear who is really interested in getting the best price. The patient theoretically would be, but in many cases, the patient pays relatively little for the drug out-of-pocket. The insurers, in many cases, are simply passing the costs of the high prices to the large employers without necessarily taking on a lot of the financial risk and burden. They just process the claims. It is really the large corporations (like General Motors or General Electric or Microsoft) that take on the financial burden for many Americans. They do not understand the pharmaceutical industry very well and they typically simply accept the prices given to them. Though they are huge companies, they are still just a small portion of the market and they lack the ability and expertise to negotiate drug prices effectively.

In 2019, you joined Maryland's first Prescription Drug Affordability Panel. Could you share a little about this appointment?

Two years ago, we saw drug prices increasing very rapidly and inappropriately in the country and Maryland passed a law against price gouging. However, the pharma industry opposed it and fought it in court, eventually getting the legislation overturned by the court. Maryland came back a year later with a different approach: instead of trying to set the price of the drug, the state would set the maximum amount that someone could pay for it. This might seem like a subtle difference but they are legally very distinct concepts. Originally the legislation was meant to apply to everyone but there was some concern about its feasibility so the legislature decided to start with applying it to state employees only.

What the Prescription Drug Affordability Panel aims to do is to look at the drugs available in the US and Maryland, determine which drugs are more expensive than necessary, and subsequently set an upper payment limit for state employees in Maryland initially. We are just getting started and I am one of the five members appointed to the panel, which is chaired by former Maryland Health Secretary Van Mitchell.

How likely is it that other states will follow Maryland's example and establish their own drug affordability panels?

There are currently about ten other states exploring this topic. Maine has done something similar; the other states are looking towards Maryland to see what happens and whether the courts think it is acceptable so there is a little bit of a 'wait-and-see' attitude.

In addition, with the ongoing COVID-19 outbreak, no one wants to slow down the development of COVID-19 treatments and vaccines so to some extent, I think state legislators are not going to take too much action in this current year.

What would you say to industry advocates that the high prices in the US market support the country's position as the most innovative pharmaceutical market globally?

I fully understand why companies charge high prices for some drugs. But the main concern I have is whether the US – or any country, really – afford some of these drugs that the industry has been developing over the past couple of years? Take the example of a spinal muscular gene therapy launched by a Big Pharma player in the US last year. It has a price tag of USD 2.1 million. Can the US afford one drug like that? Yes. Can we afford 50 drugs like that? Maybe. Can the US afford 200 drugs like that? Probably not. At the individual company level, I understand why they would want to set a price like this but from an affordability standpoint, as a country, we cannot afford to have a lot of these drugs. We really have to think hard about how we can continue to promote innovation while developing drugs that are affordable for the US and for patients.

We define 'ultra-expensive drugs' as those that cost more than the current annual US GDP per capita, which is around USD 65,000. Such ultra-expensive drugs are increasing both in numbers and utilization. Many of these are cancer drugs, gene therapies, etc. and what is worrying me is that they are becoming a much larger proportion of total US drug spending compared to before.

I agree that as a country, we have to maintain the standards for innovation, and profit is a very strong incentive for innovation. We definitely have to continue to provide incentives for innovation and for industry, this usually means substantial profits. The bigger question is, however, what is a reasonable level of profit for drug companies to have? What is a reasonable level of risk for pharma companies to have in their R&D investments and operations?

In addition, there are certain areas where the drug companies are investing a lot in research like oncology but there are also areas where they are investing very little that nevertheless still represent critical disease burdens. We are very concerned that the financial incentives are not necessarily aligned with the public needs globally. We want to ensure that there are payment and reimbursement systems set up in such a way that would incentivize drug companies to develop drugs that meet not only the greatest needs for the American public but also those in lower-income countries. I do not think we have gotten that balance right.

Do you think the public health situation in the US will improve in the near future?

I am not very optimistic that we are going to see substantial changes. The US healthcare industry represents almost 20 percent of our GDP and the healthcare lobby is very powerful both at the Federal and State levels. In many states, the largest private employer is a healthcare company. Many of the large corporations that are paying these high prices also hold significant interests and/or investment in healthcare so in general, there is just not a lot of incentive for any lobby or advocacy group to want to make a substantial change to the US healthcare system.

On another note, the US also invests relatively little in social services or prevention, unlike European countries and many other parts of the world. Therefore, we rely on the medical care system to take care of health problems instead of also working through prevention or social services. Relatedly, we do not spend very much on primary care and we have relatively few primary care physicians. In general, we are not treating the person before they get sick or even when they are mildly ill. We wait for the disease to become very severe and then we treat it, which is obviously more expensive.

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