Patents, Antitrust, and the High Cost of Health Care

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The recent series of articles in The New York Times by Elisabeth Rosenthal on the high cost of health care in the United States paints a picture of a highly dysfunctional system. To be sure, the quality of health care available to those who can afford or otherwise have access to it is extremely high. Americans today have a higher life expectancy than at any time in the past; advances in diagnostics, including genetic screening, enable better preventive care and personalized medicine; many diseases and conditions that would have killed people just a few decades ago are now curable; and while others (like AID S) remain for now incurable, many affected patients are able to live long, productive lives with the assistance of newer and better therapeutics.

And yet the negatives are all too apparent as well. Costs not only continue to increase, but often are enormously higher than what patients and insurers in other developed countries pay. At the same time, these higher costs do not translate into a longer life expectancy at birth than is enjoyed by residents of Canada, Japan, and much of Europe. Indeed, except for the absence of any redeeming humor, the manner in which drugs and health care services in this country are priced can sometimes seem like something dreamed up by a Kafka or an Ionesco: as described by Rosenthal, “products can simply disappear and prices for vital medicines can fluctuate far more than they do for a carton of milk.” The obvious questions are why costs are so high, and what can be done about them? Is patent law the principal culprit, or is it a lack of antitrust oversight, or something else? What sort of reforms might make the system better?

This article discusses the comparative role of patents, antitrust, and other bodies of law in contributing to the high cost of health care as documented in the Rosenthal series. Patents have cer-

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tainly played a part in raising health care costs, although that effect is offset to some degree by substantial countervailing benefits. More troubling has been a two-decades-long failure of antitrust law to prevent anticompetitive hospital mergers and other welfare-reducing practices, though in recent years the courts and agencies have begun to correct some of the worst abuses. Arguably more significant than the failures of either of these two bodies of law, however, are the many ways in which hospitals, drug companies, and other health-related industries often have been able to capture Congress and other entities that supposedly regulate their behavior.

**Patents**

One obvious potential source of high health care costs is the patent system. Patents, after all, are intended to induce invention by conferring monopoly rights. So, when drug companies, medical device manufacturers, and others in the health care industry obtain patents that confer market power, it should not come as a big surprise when they charge prices that exceed marginal cost. Up to a point, this ability to set price above marginal cost is a good thing because it encourages private actors to invest in creating and disclosing drugs, devices, and other inventions from which the public ultimately benefits. The whole point of the patent bargain is that the public gains something in return for conferring those monopoly rights.

At the same time, there is no universal consensus on just how much of an incentive is necessary to induce the invention of new drugs and other health care innovations. The most widely cited study, conducted by DiMasi, Hansen, and Grabowski, concluded that the average cost of developing a new drug up to the point of marketing approval was $802 million in 2000 dollars, while a subsequent time-adjusted estimate by DiMasi and Grabowski pegged it at $1.3 billion in 2005 dollars. By contrast, a 2011 study by Light and Warburton critiqued DiMasi et al.’s research and concluded that the median cost of developing a new drug was as little as $43 million in 2000 dollars. DiMasi and his coauthors have vigorously defended their work, however, and their responses to the critiques leveled by Light and Warburton appear convincing. For example, DiMasi et al.’s inclusion, as a cost of drug development, of the opportunity cost of capital calculated using the average rate of return in the drug industry over the relevant time period seems reasonable from an economic standpoint. DiMasi et al. also clearly indicate their cost estimates as pre-tax costs and provide a reasoned explanation for why the appropriate focus of drug cost estimates should be on self-originated new molecular entities as opposed to all new drug applications. In addition, the DiMasi et al. estimates are consistent with two studies published by FTC economists Christopher Adams and Van Brantner, who estimated drug company R&D costs on the basis of

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4 See DiMasi et al., supra note 4, at 163–64, 173; DiMasi et al., *Extraordinary*, supra note 6, at 1035, 1038–40, 1041–42.
publicly available information. Finally, although there are some economists who argue that all patents generate more costs than benefits and should be abolished, my sense is that most patent scholars and innovation economists who have studied the matter agree that patents do serve an important public purpose by encouraging companies to incur the risks and costs of developing new drugs. Put another way, if any industry needs patent protection, it is the drug industry. Thus, while it may be burdensome (or worse) to pay a monopoly price in exchange for a life-saving drug, it’s better than not having the drug developed at all, if that would be the consequence of patent abolition.

Of course, to state that patents may encourage research and development of new drugs does not mean that patents are the only, or even the best, policy tool for achieving this result. According to some economists, for example, prizes might work better than patents under some circumstances. Moreover, the full panoply of health-related inventions includes not only drugs but also other subject matter, such as medical devices and diagnostic methods, for which to my knowledge there are no published studies analogous to those conducted by DiMasi and others, estimating average or median R&D costs. And even if patents are necessary to stimulate the invention of drugs and other health-related subject matter, this does not necessarily mean that the optimal policy is, always and everywhere, to permit patent owners to charge whatever the market will bear. Public utility monopolies are regulated, after all; and in theory there is no obvious reason why monopolies based on patents could not be too, as they are in countries that regulate drug prices. Finally, even if we reject price controls as too radical an idea, perhaps there are some reforms that would better align the social costs and benefits of patents for drugs and other health-related subject matter.

Identifying just what those reforms might be, however, is far from easy. One possibility would be to introduce a tougher nonobviousness standard to weed out patents that offer few improvements over the prior art but enable their owners to charge above-market prices. Critics sometimes charge, for example, that drug companies devote inordinate effort in developing “me-too” drugs that offer only marginal improvements over competitors’ products.

In addition, companies sometimes engage in the practice known as “evergreening” or “product hopping,” whereby they obtain a series of patents all relating to the same drug, with the later

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11 Compulsory licensing of patented subject matter is constrained in various ways by article 31 of the TRIPS Agreement. See Agreement on Trade-Related Aspects of Intellectual Property Rights, 1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994) [hereinafter TRIPS Agreement]. And to my knowledge developed countries today rarely if ever require the compulsory licensing of drugs. They do sometimes impose price controls, though, and apparently this practice is viewed as compatible with TRIPS. See Thomas F. Cotter, Market Fundamentalism and the TRIPS Agreement, 22 CARDOZO ARTS & ENT. L.J. 307, 328 n.97 (2004).

patents claiming merely minor variations in dosage or packaging. The effect can be that generic competition is deterred and delayed, as explained more fully below.\(^{13}\) As Ben Roin points out, however, even if one concedes that these practices on balance reduce social welfare, adopting a tougher nonobviousness standard might not be an appropriate response.\(^{14}\) The problem is that nonobviousness is evaluated as of the date of invention (or, for applications filed on or after March 16, 2013, as of the date of filing),\(^{15}\) and this date typically occurs years before any clinical tests have established that the drug is safe and effective, let alone whether it will be a modest success or a significant breakthrough. Nonobviousness, in other words, is only loosely tied to any concept of social value; and while this might seem like a defect of the patent system generally, it is hardly obvious (no pun intended) how patent examiners could predict the social value of an invention far in advance of any clinical studies. Requiring that examination be deferred until after the completion of clinical studies also seems unworkable, not only because it would require significant changes to the patent statute’s definition of “prior art,” but also because, as Roin notes, drug companies are reluctant to go forward with clinical testing until they have a patent in hand.\(^{16}\)

It is also worth noting that various patent doctrines eliminate or reduce patent owners’ ability to extract supracompetitive profits under certain circumstances. For example, a diagnostic or therapeutic method that in substance is nothing more than a recitation of a naturally occurring correlation (for example, between the presence of an elevated level of a metabolite in the blood and the need to increase the dosage of a prescribed medication) is considered a patent-ineligible law of nature; and the Supreme Court recently held that human genes are patent-ineligible products of nature.\(^{17}\) In addition, Section 287(c) of the Patent Act prevents an owner from enforcing a patent claiming a medical or surgical procedure against a medical practitioner. The doctrine of double patenting prevents a drug company from patenting an obvious variation over its own previously patented drug,\(^{18}\) and the inherency doctrine precludes patenting a metabolite that is produced in the body upon ingestion of a prior art drug.\(^{19}\) And while the practice of permitting patent owners to file continuations—separate applications for variations derived from an initial “parent” application—is largely unknown outside the United States, and in the past may have contributed

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\(^{13}\) See Stacey L. Dogan & Mark A. Lemley, Antitrust Law and Regulatory Gaming, 87 Tex. L. Rev. 685, 687 (2009) (”The pharmaceutical industry has witnessed this behavior for years, as branded drug companies have used exclusionary tactics to stay one step ahead of generic entry. In one species of this behavior—called ‘product hopping’—the branded company makes repeated changes in a drug’s formulation to prevent generic substitution, rather than to improve the efficacy of the drug product.”).


\(^{15}\) For applications filed prior to March 16, 2013, the applicable text reads “A patent may not be obtained . . . if the differences between the subject matter sought to be patented and the prior art are such that the subject matter as a whole would have been obvious at the time the invention was made to a person having ordinary skill in the art to which said subject matter pertains.” 35 U.S.C. § 103(a) (2006). For applications filed on or after March 16, 2013, nonobviousness is evaluated as of the date of filing. See 35 U.S.C. § 103 (2012) (“A patent . . . may not be obtained . . . if the differences between the claimed invention and the prior art are such that the claimed invention as a whole would have been obvious before the effective filing date of the claimed invention to a person having ordinary skill in the art to which the claimed invention pertains.”).

\(^{16}\) See Roin, supra note 14, at 545.


\(^{18}\) See, e.g., Sun Pharm. Indus. v. Eli Lilly & Co., 611 F.3d 1381, 1384–85 (Fed. Cir. 2010).

\(^{19}\) See Schering Corp. v. Geneva Pharm., Inc., 339 F.3d 1373, 1379 (Fed. Cir. 2003) (“In general, a limitation or the entire invention is inherent and in the public domain if it is the ‘natural result flowing from’ the explicit disclosure of the prior art.”).
to evergreening, amendments passed ten years ago have reined in drugmakers’ ability to use
continuations to ward off generic competition.20

To sum up, patents surely contribute to the high cost of health care. At the same time, they also
(most likely) serve a valid public purpose. To the extent patents drive prices higher than they need
to be to stimulate invention, some reforms to patent law may be desirable or other regulatory
responses may be appropriate. But it’s far from clear that patent doctrine itself requires a major
overhaul.

Antitrust

A less defensible cause of high health care costs is the insufficient level of effective antitrust
enforcement in health care markets. Three examples are provided below.

First, the market for health care related services has become remarkably more concentrated
over the past two decades. Hospital consolidation took off in the early 1990s. Since that time there
have been over 1000 hospital mergers or acquisitions in the United States, including over 500
between 2007 and 2012.21 Concentration within health care markets, not surprisingly, has steadi-
ly risen. According to Capps and Dranove, the average metropolitan statistical area HHI in the
market for hospital ownership as of 2009 was “roughly 4700,” well above the level (2500) the
enforcement agencies consider highly concentrated.22 The agencies themselves lost six consec-
utive cases against hospital mergers between 1993 and 1995, and did not block a single one for
over a decade.23 In a 2004 article, Thomas Greaney argued that courts permitting these mergers
(and other practices Greaney believes were questionable) were applying theory divorced from
facts by assuming away pre-existing market imperfections in defining geographic and product
markets.24

The empirical evidence appears to be consistent with Greaney’s critique. In the 2006 report
cited above, Vogt and Town stated that the “great weight of the literature” to date showed that hos-
pital consolidation “raised prices by at least five percent and likely by significantly more.”25 A 2011
update by Gaynor and Town reported, on the basis of empirical studies published since 2006, that
increases in hospital market concentration had led to increases in the price of hospital care; that
hospital mergers in concentrated markets had generally led to significant price increases (“most

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24 See Thomas L. Greaney, Chicago’s Procrustean Bed: Applying Antitrust Law in Health Care, 71 ANTITRUST L.J. 857, 858–59 (2004) (“Chicago [School]’s tendency to brush over market imperfections in health care often causes tribunals to miss important features of health care markets and misjudge the impact of antitrust claims.”).

25 VOGT & TOWN, supra note 21, at 4.
Until recently, “reverse payment” or “pay-for-delay” settlements . . . were all but per se legal in some circuits.

Since the early 2000s, however, the tide has started to turn. In 2004, the FTC filed a complaint against the then-consummated merger involving Evanston Northwestern. The Administrative Law Judge and the Commission both found the merger to be anticompetitive, and the matter terminated with a conduct remedy under which the two previously separate entities must negotiate prices separately. In 2008, the FTC opposed a proposed acquisition by Inova Health System Foundation Inc. of Prince William Health Systems, which the merging partners ultimately abandoned. In 2012 the FTC ordered the divestiture by ProMedica Health System, Inc. of St. Luke’s Hospital in Lucas, Ohio, and in 2013, following a favorable Supreme Court remand, entered into a consent agreement for a conduct remedy with two health care providers in north Georgia.

It is probably too late to undo some other consummated anticompetitive mergers, however; and some commentators have expressed concern that the Federal Trade Commission/Department of Justice Statement Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program—a keystone of the Affordable Care Act—could encourage consolidation that will result in clinical providers acquiring or exercising greater market power.

Second, until recently, “reverse payment” or “pay-for-delay” settlements of pharmaceutical patent litigation between brand-name and generic drugmakers were all but per se legal in some circuits. This was despite the FTC’s estimate that such agreements “on average prohibit[ed] exceeding 20 percent”). And that for certain procedures, concentration reduced quality while competition had the opposite effect.

26 See Martin Gaynor & Robert Town, The Impact of Hospital Consolidation—UPDATE 2 (June 2012), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261. For example, one of the more recent studies Gaynor and Town review, Deborah Haas-Wilson and Christopher Garmon’s Hospital Mergers and Competitive Effects: Two Retrospective Analyses, 18 INT’L J. ECON. BUS. 17, 27–30 (2011), concludes that a 2000 merger of two suburban Chicago entities, Evanston Northwestern Healthcare Corporation and Highland Park Hospital, allowed the merged entity to charge significantly higher prices than would have been possible absent the merger. Haas-Wilson and Garmon further conclude that the merger did not result in the merged entity accepting significantly more complicated cases or improving quality, either of which could provide an alternative explanation for the increase in price. They also report that another merger occurring at about the same time in Waukegan, Illinois, did not exhibit these price effects. Id. at 28–29.


generic entry for nearly 17 months longer than agreements without payments” and “cost American consumers $3.5 billion per year.” To be sure, some payments from brand-name to generic drug-makers arguably should be permitted, given the peculiar framework of the Hatch-Waxman Act (which, among other things, permits the patentee to sue before the generic firm has begun marketing any products). Nevertheless, elementary economics suggests that when the consideration flowing from brand-name to generic exceeds the latter’s expected profit from marketing a generic drug, the most reasonable inference is that the brand-name is simply paying its competitor to exit the market.

Fortunately, the Supreme Court appears to have reined in the use of pay-for-delay settlements in its 2013 decision in FTC v. Actavis, Inc., although the precise framework for evaluating such settlements under the Sherman Act still remains to be worked out.

Third, antitrust courts arguably could play a greater role than they traditionally have in scrutinizing product hopping, along the lines suggested in Abbott Laboratories v. Teva Pharmaceuticals USA, Inc. (though of course this would depend on parties bringing the appropriate claims). In the Abbott case, Abbott filed a series of New Drug Applications (NDAs) for different formulations of the same drug (TriCor), and after each was approved changed the code for the old version in the National Drug Data File to read “Obsolete.” This did not prevent generic firms from selling generic versions of the old formulations for which they had obtained FDA approval, but it did limit the marketability of the generic versions because the code change prevented pharmacists from substituting the generic for the new brand-name formulation. The court rejected Abbott’s argument that its conduct was per se legal, concluding instead that the generic firms had stated a claim under the rule of reason. As discussed by Lemley (who represented one of the generic firms) and

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34 See, e.g., HERBERT HOVENKAMP ET AL., IP AND ANTITRUST: AN ANALYSIS OF ANTITRUST PRINCIPLES APPLIED TO INTELLECTUAL PROPERTY LAW § 15.3a1, 15.38 n.147, 15.41-15.42 (2d ed. 2010).

35 133 S. Ct. 2223, 2237 (2013) (“In sum, a reverse payment, where large and unjustified, can bring with it the risk of significant anticompetitive effects; one who makes such a payment may be unable to explain and to justify it; such a firm or individual may well possess market power derived from the patent; a court, by examining the size of the payment, may well be able to assess its likely anticompetitive effects along with its potential justifications without litigating the validity of the patent . . . .”).

36 432 F. Supp. 2d 408 (D. Del. 2006).

37 See id. at 415 (“Pharmacists may dispense the generic equivalent for a branded drug when the branded drug is prescribed by a physician. Such substitution is allowed, however, only if the generic drug has been ‘AB-rated’ by the FDA, which means not only that the generic drug is bioequivalent to the branded drug, but also that the generic has the same form, dosage, and strength. Therefore, an approved generic drug that is not AB-rated against a currently available branded drug, because, for example, the drugs have different formulations or dosages, may not be substituted for the branded drug and may only be sold, if at all, as a separately branded, rather than generic, drug.”); id. at 416 (“After the NDA for the tablet formulation was approved, Defendants stopped selling TriCor capsules and also bought back the existing supplies of those capsules from pharmacies. In addition, Defendants changed the code for TriCor capsules in the National Drug Data File (‘NDDF’) to ‘obsolete.’ The NDDF is a private database that provides information about FDA-approved drugs. Changing the code to ‘obsolete’ removed the TriCor capsule drug formulation from the NDDF, which prevented pharmacies from filling TriCor prescriptions with a generic capsule formulation.”).

38 Id. at 422.
Dogan, however, the Teva court’s approach contrasts with the more deferential approach of some other courts in cases involving firms that are subject to pervasive regulation.39

On balance, it’s fair to say that antitrust has not always been aggressive enough in responding to anticompetitive practices that have contributed to the high cost of health care. On the other hand, antitrust’s role is limited. It does not (and should not) condemn high prices that result merely from the possession of substantial market share; and, except in certain discrete circumstances like those presented in Abbott Labs, it generally does not (and probably should not) prevent firms from exploiting otherwise lawful opportunities. Whether some of those opportunities should exist at all, however, is another matter.

Regulation and Other Obstacles

I argued above that both patents and lenient antitrust enforcement have contributed to some extent to the high cost of health care in the United States (though patents at least contribute something in return). Of possibly greater significance, however, is a regulatory system that is subject to capture, in combination with other obstacles the effect of which is to render fundamental reform extremely difficult. According to the Center for Responsive Politics, the health industry spent $359,164,761 on federal government lobbying in 2013; in the preceding five years, the annual sum approached or exceeded $500 million.40 Lobbying, of course, has long qualified as protected First Amendment activity, but the Citizens United decision41 promises to expand corporations’ ability to influence elections all the more.

Space constraints prevent me from exploring these points in depth, but as described in Rosenthal’s series and other sources, a list of causative factors might include the following.

- Protecting Incumbent Hospitals from Competition. Certificate-of-need (CON) laws in force in 36 states and the District of Columbia arguably work to the advantage of incumbent hospitals by imposing barriers to entry in the construction of new facilities.42

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39 See Dogan & Lemley, supra note 13, at 712–14. But see Walgreen Co. v. AstraZeneca Pharm. L.P., 534 F. Supp. 2d 146 (D.D.C. 2008) (dismissing a complaint alleging that a drug company violated § 2 by marketing a new drug that allegedly was no better than an old drug, where the new drug and generic substitutes for it remained available in the market). A fourth possible antitrust response, suggested to me by Professor Bill Page, might be to challenge some of the contractual provisions imposed by device manufacturers as described in Rosenthal, Hip, supra note 1, though of course whether any of them are sufficiently exclusionary in nature to raise antitrust problems would depend on the facts. See also C. Scott Hemphill & Tim Wu, Parallel Exclusion, 122 YALE L.J. 1182, 1246–48 (2013) (discussing antitrust claims against surgical instrument makers’ allegedly exclusionary practices and arguing that Standard Oil Co. v. United States, 337 U.S. 293 (1949), permits liability based on “cumulative foreclosure,” i.e., the aggregate effect of vertical restraints even in the absence of horizontal collusion among manufacturers).


42 See U.S. DEPT OF JUSTICE & FED. TRADE COMM’N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 22 (2004), available at http://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarept.pdf (“The Agencies believe that, on balance, CON programs are not successful in containing health care costs, and that they pose serious anticompetitive risks that usually outweigh their purported economic benefits.”). For more recent work, see, e.g., Traci L. Eichmann & Rexford E. Santerre, Do Hospital Chief Executive Officers Extract Rents from Certificate of Need Laws?, 37 J. HEALTH CARE FIN. 1, 2, 12 (2011) (stating that “the verdict is still out” on whether CON laws influence health care spending, but that the literature consistently has found that they do reduce the number of hospitals and hospital beds; and presenting preliminary evidence that CON laws increase hospital CEO pay, “function as barriers to entry and . . . raise the overall cost of health care”); TRACY YEE ET AL., HEALTH CARE CERTIFICATE-OF-NEED LAWS: POLICY OR POLITICS? 2 (2011) (although the evidence of the effect of CONs on health care costs has been inconclusive, the process of obtaining a CON “often takes several years,” and CONs “tend to be heavily influenced by political relationships”).
Protecting Incumbent Drug and Device Makers from Competition. Even after the Hatch-Waxman Act, FDA rules make it more difficult, in comparison with practices in other countries, for firms to demonstrate that their products are as safe and effective as approved drugs and devices.43 In addition, the FDA does not take into account matters such as cost effectiveness, access, and affordability when considering whether to approve a new drug or device, in the manner that national health services elsewhere routinely do. On the other hand, firms can obtain exclusive marketing rights for conducting clinical studies on old (pre-FDA) drugs that had never before been tested for safety and efficacy. The result has been to take products such as the anti-gout drug colchicine, which has been in use since the 6th century A.D., out of the public domain.45

Lack of Transparency. Only recently has the federal government made available hospital chargemasters (price lists) for common inpatient and outpatient services and published regulations requiring the disclosure of pharmaceutical company payments to physicians.46 Even so, as Steven Brill points out in his Time article, “Pharmaceutical and medical device companies routinely insert clauses in their sales contracts prohibiting hospitals from sharing information about what they pay and the discounts they receive.”47 According to the Government Accountability Office, this lack of transparency “raises questions about whether hospitals are achieving the best prices possible.”48 Rosenthal notes that gag clauses also sometimes prevent employers from knowing what rates insurers have negotiated on their behalf.49 This lack of transparency makes competition on the basis of price more difficult than it otherwise would be.

Bargaining Power and Transaction Costs. Contrary to practice in much of the rest of the world, drug and device makers, as well as health care providers in the United States, are generally free to charge whatever the market will bear for their products. For example, Congress has specifically forbidden Medicare from negotiating favorable prices for prescription drugs in

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44 See, e.g., Steven Grossman, FDA Should Consider Cost in Some Decisions, The Health Care Blog (Oct. 5, 2011), http://thehealthcareblog.com/blog/2011/10/05/fda-should-consider-cost-in-some-decisions/ (arguing that “FDA . . . plays a role (however unintentionally) in exacerbating the crisis in affordable cancer care,” and that it “may need to find ways to favor less effective or riskier products only because they can be made available at a market-driven price”); Rosenthal, Breath, supra note 1, at A1 (“Experts say, a significant problem is that none of the agencies that determine whether medicines come to market in the United States are required to consider patient access, affordability or need.”).


47 Brill, supra note 1, at 34.


It's hard not to speculate that regulatory problems generate the most significant, and unnecessary, costs of the U.S. health care system, far in excess of the net costs generated by patents or by weak antitrust enforcement. At the end of the day, it's hard not to speculate that regulatory problems generate the most significant, and unnecessary, costs of the U.S. health care system, far in excess of the net costs generated by patents or by weak antitrust enforcement, and that some form of universal, single payer health care along the lines of what is found in Canada, Europe, and elsewhere would be an improvement over our current high-cost system. But despite the fact that universal care has been championed over the years by such luminaries as (Republican) President Theodore Roosevelt56

Rulings on Commercial Speech. In the nearly 40 years since the Supreme Court first extended First Amendment protection to commercial speech, the Court has applied commercial speech doctrine to hold unconstitutional a Vermont law that attempted to constrain health care costs by restricting the sale to pharmaceutical companies of “pharmacy records that reveal the prescribing practices of individual doctors,”53 as well as a federal law that prohibited certain ads by compounding pharmacies.54 In addition, FDA regulations and commercial speech doctrine permit drug companies to engage in direct-to-consumer advertising, a practice that is absent from almost every other country.55

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See 42 U.S.C. § 1395l(t)(14)(A)(iii) (2012) (“The amount of payment under this subsection for a specified covered outpatient drug . . . that is furnished as part of a covered OPD service . . . shall be equal . . . to the average acquisition cost for the drug for that year . . . as determined by the Secretary taking into account the hospital acquisition cost survey data . . . or if hospital acquisition cost data are not available, the average price for the drug . . . as calculated and adjusted by the Secretary as necessary for purposes of this paragraph.”); § 1395w-111(i) (“the Secretary . . . (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs”).


On the other hand, one reform often championed by the political right—tort reform—actually does not appear to have had a significant impact on reducing health care costs in Texas. See Myungho Paik et al., Will Tort Reform Bend the Cost Curve? Evidence from Texas, 9 J. EMPIRICAL LEG. STUD. 173 (2012).

See Alexander Lane, Obama Invokes Republican Icons on Health Care, POLITIFACT.COM (Mar. 5, 2009, 6:39 PM), http://www.politifact.com/truth-o-meter/statements/2009/05/05/barack-obama/obama-goes-back-to-his-republican-roots-on-health/ (substantiating the claim that Roosevelt championed a national health care program).
and the (emphatically nonsocialist) economist Friedrich von Hayek, polls indicate that large numbers of Americans still view the rather mild version of universal care that is embodied in the Affordable Care Act in unfavorable terms. And to be fair, universal health care is hardly perfect: the litany of its unintended consequences, including sometimes long waits for services and Spartan facilities, is well-documented too. Perhaps innovation would suffer as well if Americans were not so willing to fund it by paying higher prices for drugs, devices, and other health-related products and service—though this hardly suggests a rationale for approving protectionist policies that have nothing to do with innovation. And maybe there is some better alternative to both our current system and the single-payer model, though for now I remain somewhat skeptical.

In any event, and for better or worse, over the course of more than a century, we have collectively chosen a different model for the provision of health care than has much of the developed world. If we are unwilling to change, we must accept the bitter with the sweet. As Pogo would say, we have met the enemy, and he is us.

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57 See F.A. HAYEK, THE ROAD TO SERFDOM 120–21 (1944):

Where, as in the case of sickness and accident, neither the desire to avoid such calamities nor the efforts to overcome their consequences are as a rule weakened by the provision of assistance—where, in short, we deal with genuinely insurable risks—the case for the state’s helping to organize a comprehensive system of social insurance is very strong. There are many points of detail where those wishing to preserve the competitive system and those wishing to supersede it by something different will disagree on the details of such schemes; and it is possible under the name of social insurance to introduce measures which tend to make competition more or less ineffective. But there is no incompatibility in principle between the state’s providing greater security in this way and the preservation of individual freedom.

58 See, e.g., CNN Poll: Support for Obamacare Slightly Edges Up (Mar. 11, 2014) (reporting 57% opposed, though only 39% “because it is too liberal”), http://politicaltickerblogs.cnn.com/2014/03/11/cnn-poll-support-for-obamacare-edges-up/.