complain about high prices. But emphasis on drug safety and efficacy inevitably redounds to the advantage of the major firms, who would much rather fight on the battleground of relative quality than of relative prices. Their argument has two parts: First, drug prices are related to costs, particularly quality control costs. Second, drug quality and hence safety and efficacy is related to these same costs. Hence it is asserted that one cannot divorce questions of cost and price from questions of safety and efficacy; therefore, since problems of drug quality, being matters of life or death, are obviously more crucial than drug price problems of mere dollars and cents, steps to assure high quality should take precedence over economic reforms. Economic reforms are correspondingly delayed. (This was the net effect of the otherwise admirable Kefauver-Harris Act of 1962). The argument is faulty in several respects. First, drug prices are not related to drug costs, but instead to demand and ability to pay. Second, while drug quality obviously depends upon care exercised in manufacture, the cost of quality control has been shown to be a very small part of total costs, and the difference in cost between a minimal satisfactory program and a "de luxe" program would not begin to account for the difference in prices between the generic drug and its brand name equivalent.

But to return to the question: what can an economist contribute to drug law reform hearings? If the data were made available, he could analyze cost-price conditions within the individual drug firms, and the pattern of inter-firm price and product competition, and arrive at an informed judgment regarding the status of competition in the industry. But such data have not been made available, even to economists retained to defend the industry.[1]

In view of the absence of the data in the analysis of which the economist has a comparative advantage, what constructive role can he play? Primarily that of coordinating and synthesizing the economic aspects of the data which is in the record, and evaluating the economic relevance or credibility of certain of the arguments advanced by the drug interests. But since much of the evidence and many of the arguments transcend the realm of economic analysis as such, an economist is vulnerable to objections that he is exceeding the limits of his professional competence.

Certainly the economist is not alone in this. During the drug industry investigations in the English-speaking countries, testifying physicians have been criticized for not being economists, economists have been challenged for not being physicians or pharmacologists, medical educators have been chided for not being doctors in full-time private practice, etc. But until the ideal witness appears,[2] someone who is less than fully qualified has to stick his neck out and attempt to put the entire picture together. There are reasons why an economist who specializes in the area of industrial organization and regulation is not the least qualified of all specialists to make such a presumptuous attempt. First and foremost,

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[1] As Professor Markham stated before this Subcommittee on December 19, 1967, in response to just such a question, "you are just not going to get those data, and I do not think—I would be less than honest if I said I would try to get them, implying that I could get them for you." (transcript, volume 23, p. 2805). Markham apparently referred not only to the confidential status given the information, but also questioned whether or not drug firms bothered to make all the cost allocations involved. Although it is to be admitted that many of the calculations can be made only on the basis of arbitrary assumptions, one would expect that well-managed firms would find it prudent to undertake such analyses for their own information. In fact, Dr. M. A. Phillips, in his Sainsbury Committee memorandum to the British Ministry of Health stated that the drug industry was no different from other organic chemicals industries in observing the customary precautions of making detailed cost studies prior to engaging in producing projects. These studies include the costs of research and development and of promotion. Dr. Phillips' statement is unusually authoritative in that he is a drug industry consultant who has made many economic evaluation studies for drug firms. Phillips complains that "It has been found very difficult to obtain figures for the cost of research and development and of promotion and advertising, although this must be known to those who have to spend this money in these ways . . ." and explains that even with the approximations his organization has to use in estimating these costs, he is satisfied that the accuracy of the estimates for these items is within 25 per cent. *See Competitive Problems in the Drug Industry*, Part I, pp. 54–55, of the *Hearings* before this Subcommittee on the present matter. (It might be observed that only if there is a very large gap between cash flow and expenditures is a company actually likely to indulge in some carelessness or negligence in the relating of total costs to individual items sold.)

[2] The ideal witness would probably be a practicing family physician who has also in the past been a pharmacist, a pharmacologist, a medical educator, a hospital administrator, a drug industry executive, a compiler of official therapeutic compendia, a medical public welfare program administrator, a high official variously with the AMA, the PMA, and the FDA, a patent attorney, a research scientist, an economist, and a member of Congress.