

cross-licensing agreements requires the mutual compromise of patent monopoly positions, and may well stimulate such meetings of the minds as will lead to the development of a greater sense of community of interest in policies regarding prices, production, and participation in world markets.

In connection with this last point, it should be emphasized that the United States drug industry is not unacquainted with outright collusion. In December 1967, Pfizer, Lederle, and Bristol Myers were convicted by the Federal District Court of New York City of conspiracy in restraint of trade, conspiracy to monopolize, and monopolization in the tetracycline market. (Squibb and Upjohn were named co-conspirators but not defendants.)

A further respect in which the drug market can be distinguished from other markets is in the involuntary nature of the purchase. While an individual ordinarily ought to pay no more than the competitively determined full supply price for a product, he should also pay no less than this price since in order to supply his wants, the economy has had to allocate scarce resources which could have been used alternatively in the production of other products. But there is a difference between paying the full cost of financing an activity deliberately engaged in, in contrast to one forced by accident or misfortune upon the buyer through no fault of his own. This is to suggest that the financing of drug purchases, like other aspects of health care, has an element of insurance against risk in it. Such insurance arrangements could conceivably be either public or private. A prudent man of sufficient income might participate in a voluntary health insurance program including drug costs. But the required income to make participation attractive does not depend upon the "full competitive cost" of drug supply, but instead upon actual prices charged in highly non-competitive markets. Unless drug prices can be made reasonable, the possible expenses of drug therapy under a comprehensive private health insurance program might be so great that enormous premiums would be required. Under these circumstances, the expenses of drug therapy would not constitute an insurable risk for practical purposes. This is all the more applicable to public health insurance and welfare programs, of the medicare variety or otherwise. Truly comprehensive drug coverage under such plans might allow sellers of patented high-price drugs to levy a publicly-underwritten tribute on the sick and afflicted and divert a not-negligible portion of tax revenues and the national income into the hands of the pharmaceuticals industry. The only difference, fortunately, is that public authorities are in a position to exert more effective efforts to discipline high drug prices than are private insurance companies.

The above considerations should be kept in mind when assessing the effects of the great variety of drug industry activities and expenditures on the price of drugs, when such costs are generally borne in full by persons involuntarily afflicted, whose earning power and ability to pay may be greatly reduced by the very circumstances which make medication imperative.

The absence of workable competition among sellers is compounded by the barriers which consumers face in obtaining information regarding drug prices and quality. If neither a seller's customers nor his rivals can force him to compete, what limits are placed on his ability to exploit his customers? Essentially only two—self-restraint and public constraint.

Self-restraint is ordinarily an impediment in the management of a business enterprise, and under competitive market conditions would detract from efficiency. During the Kefauver hearings several witnesses referred to their impressions that there had been within memory some decrease in the degree of self-restraint in marketing among drug firms. Actually, it is to be doubted that self-restraint in itself ever posed much of a barrier to high profits. Upjohn, for example, made over 30 per cent after taxes on its net worth in each of the deep depression years 1930-1935.<sup>6</sup> But this does not necessarily contradict the observations that self-restraint was still more prevalent among drug firms prior to the second world war. In the post-war era, however, it became obvious to all that the profit possibilities inherent in the "Miracle Drugs" era of the industry's history were simply too vast not to be fully and intensively exploited. Although it did not prove possible for new small firms to enter the market and become genuine factors to be reckoned with in the industry, larger firms found it possible to diversify by merging with existing drug houses, and producers of bulk chemicals and fine chemicals found it profitable to integrate forward into drug making and market-

<sup>6</sup> *Hearings on Administered Prices*, Part 20, p. 11082.