traffic will bear." Now as long as the act of purchase is voluntary, no one will literally pay more than what the product is worth to him. In both monopolistic and competitive markets, the market price is equal to the evaluation placed on the good by the least interested buyer who actually does make a purchase. But in pure competition, with no way of mutually restricting output, total production will generally be large and prices low, while under monopolistic circumstances, output will be reduced in the interest of enhancing prices. This means that the chances of the typical buyer obtaining a substantial free increment of "use value" above price paid is much less under monopoly. But the major difference between monopoly and competition is in the relationship between price and cost of production. In pure competition the two are identical. But if monopoly power is present, price is also a function of the elasticity of demand and will exceed production cost in direct proportion to the insensitivity of demand to price.

Therefore when spokesmen for the drug interests argue that the consumer is paying no more than the drug is worth to him, the obvious answer is: of course not!! Unless force is used, no one can be induced to pay more for anything than it is worth to him, no matter what sort of fleecing or price-gouging scheme, may be employed. It is not surprising that a drug may be worth more to a sick person than its cost of production, but this does not justify charging more, and in a reasonably competitive market, prices would be much closer to cost than to need-value.[39]

The above is a general treatment of the contrast between the relationship of demand to prices in monopoly and in competition. In drugs, the argument applies with even more force because of the extreme insensitivity of demand to price, and the way in which this final consumer demand is mediated through the physician. How should the needs of the sick be reflected in the market demand for drugs? Ideally, the total potential market for a drug or group of related drugs is measured by the total need for medication on the part of the individuals afflicted by all the various disorders which are capable of being treated best by the drug or group of drugs. Economically, the total effective amounts demanded at the level of market price may fall short of total physical need in the case of those with low incomes and no access to public care. But effective market demand may also exceed ideal total physical need to the extent that individuals not suffering from those conditions for which the drug or drugs are of use may nevertheless be treated with them. For any given drug it then follows that the actual market is comprised by the total effective demand for medication on the part of all individuals who can be induced to consult physicians, and who are afflicted, or can make it seem convincing that they are afflicted, by those disorders for which doctors may be inclined or persuaded to prescribe the particular drug. The challenge to drug marketers then consists primarily in persuading physicians, but also to some extent in spreading the good word to the general public that Brand X can cure symptom Y.

And drug marketers doubtless earn their salaries. Changes in the effective demand (i.e., prescriptions written and purchased as written) for individual drugs are brought about by the familiar techniques of direct mail advertising, journal advertising, the dividend of free samples, the financing of symposia, the rental of exhibit space at conventions, and above all the insistence of the ever-present detailman. Although advertising cannot yet manipulate the total incidence of genuine disease, it can readily shift effective demand from one drug to another. And advertising can in a sense actually create demand, even for drugs. Articles planted in newspapers or magazines may mention the name of a drug alleged to be useful in treating certain conditions, and may thus bring to the attention of more people who suffer (or imagine they suffer) from such

[39] Examples where representatives of drug firm interests have defended high drug prices as being no more than what the drug is "worth" to the buyer are legion. The most recent exposure of this Subcommittee to this argument is embodied in page 7 of Professor Simon Whitney's written statement in behalf of PMA, where he states: "If a $5 prescription, or 6 of them, will keep a patient from losing a couple of days pay or spending a night in a hospital, the price is reasonable." This can scarcely be taken seriously by an economist unless the price is also commensurate with the competitive supply cost of the drugs. But no one who has presented this argument has so far been able to outdo Austin Smith, who mused publicly during the Kefauver Hearings: "I wonder if any member of this Subcommittee knows how much it costs to die? . . . death costs about $900 . . ." Hence Smith has proved conclusively that any price less than $900 for a handful of pills (32 in this case) is a bargain since it must be worth at least $900 to the patient to avoid the expense of demise. Hearings on Administered Prices, Part 19, p. 10615.