



Beyond US boundaries:
Is the US Congress sacrificing EU patient safety?

Brian Crowley

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About the Speaker

Brian Lee Crowley is the founding President of AIMS, the Atlantic Institute for Market Studies, in Canada. AIMS is one of the world's most honoured think tanks. It is a four time winner of the prestigious Sir Antony Fisher Award, which recognizes excellence in public policy think tank publications and projects. No think tank in the world has won this honour more times than AIMS. In its tenth anniversary year (2004-05), AIMS also won the Templeton Freedom Prize for Institute Excellence.

He has been a Salvatori Fellow at the Heritage Foundation in Washington, a diplomat for the EEC Commission, an aid administrator for the UN in Africa, an advisor to the Quebec government on parliamentary and electoral reform and a Parliamentary Intern at the House of Commons in Ottawa. Crowley is a frequent commentator on political and economic issues for the CBC, Radio-Canada and many other media, and is a former member of the Editorial Board of The Globe and Mail (one of Canada's two national newspapers). He is currently an adviser to the federal government

Brian Crowley:

Thank you to Stephen Pollard and CNE for the invitation to be here. Please let me say at the outset that while I occasionally advise Canadian governments on a wide variety of topics, I am not here in any capacity as a representative of any government and my comments have nothing to do with Canadian government policies.

Forget about how you feel about the current US administration or the war in Iraq. These are just moments in a long history. Taken in the round America is a great and admirable society that does much good in the world and gets little credit, gratitude or recognition for it. Such is the burden of power and luckily for all of us, America does not shrink from its responsibilities.

But for the only remaining global super-power, America can be amazingly parochial. We all have our stories in this regard. In *The Last Hurrah*, Edwin O'Connor's brilliant novel of city politics in Boston in the 1950s, the old pol who had been mayor for years but knew nothing of the outside world nevertheless had a foreign policy. That foreign policy was driven by the dictum that all politics is local, and his city had lots of Italians and Irish. Therefore, the mayor's foreign policy could be summed up in the following two principles: 1) All of Ireland must be free and 2) Trieste is an Italian city, even though he knew nothing of the consequences of the policies he so blithely espoused for the people who would have to live with them in Ireland and the Adriatic. Sometimes people like that get to be president.

And of course no one knows Americans better than Canadians, because as a middle power living cheek by jowl with America, we cannot afford to be indifferent to them, while they are scarcely aware of our existence, despite the fact that we are their largest trading partner, their biggest source of energy, their partner in NAFTA, their ally in NATO and NORAD and a secure and friendly neighbour in a sometimes dark and uncertain world. Yet because of the imbalance between our two nations, the consequences of their actions can be dire for us, while America is likely blithely unaware that they are doing anything that affects us. America fills our field of vision, whereas theirs is filled by their problems. They do not number us among their problems. And that is often our chief problem.

Reimportation of prescription drugs is a classic case of America not even realising that what they are doing may affect Canadians, for better or for worse. And now, I understand, they are about to extend the same courtesy and delicacy of feeling to you. I am here to tell you that you should not let them do so, for not only are they acting in blissful ignorance of your interests and how they may be affected, but they are trying to solve their own very serious health care problems at your expense. Yet their "solution", while creating disruption for you, will not and cannot solve the problem that is preoccupying America. That, in a nutshell, is the talk I will give today.

In understanding the challenge that parallel importing (to use the European term) represents, it is necessary to think about the way both the drug industry and the economy function and to consider both the role of insurance in the drug market and the way American public drug benefits are structured. I will keep all this as non-technical as possible and I would like to say right up front that a great deal of what I have to say is drawn from excellent work done for my Institute by Professor Brian Ferguson, one of Canada's leading health care economists.

I believe that the best place to start is with the economics of drugs. Pharmaceutical companies have large fixed costs and low variable costs. In the case of drugs, the fixed costs are primarily the up-front research, development and testing costs necessary to bring a drug to market, and the variable costs are the actual production costs -- the costs of physically making pills once the therapeutic agent has been discovered and proven. As I like to say, the first dose of a new drug costs US\$800-million (on average), but the second dose costs, say, 50 cents. This is the reason why drug companies need patent protection -- without it they would not be able to recover their research costs.

It is important, also, to remember that the handful of drugs which do successfully reach the market have to cover the costs of all of the promising but ultimately blind alleys down which researchers went. Finally, recall that only a handful of drugs are really successful (i.e. the so called "blockbusters"). The rest of the drugs on the market cover their production costs and make some contribution towards industry research costs, but are not profitable when equal shares of the sunk costs of the industry's research enterprise are attributed to them. It is also important to

remember that, while a patent's life (and therefore monopoly status of a drug) is for twenty years, that is twenty years from the date at which the patent was filed, and filing comes early in the drug development process. Typically a drug will have about seven years of patent protection left when it comes to market. The pharmaceutical industry is, therefore, very dependent on a handful of high-profit drugs for its profitability.ⁱ Parallel importers, by necessity, focus on these drugs, precisely because they are the ones with the greatest difference between the costs of production and the market price. But by focusing on the most profitable drugs, they cut significantly into the drug companies' revenue.

Does that matter? Yes, because the evidence is also clear that drug industry research is funded to a very significant degree by retained earnings. The long development period necessary before a drug reaches market and the low probability of any given single drug actually making it to market, let alone being highly profitable, makes any particular research line a very risky investment. If drug companies had to fund their research entirely from the financial marketsⁱⁱ, the rate of return that the markets would demand in order to compensate for the riskiness of the investment would be very high indeed. Thus, it makes sense for drug companies to fund their research from cash flow. This is consistent with the data showing that drug company R&D spending appears to be driven very much by fluctuations in their gross profitability. Seen in this light, there is much validity to the claim that parallel importation, focused as it is on the most profitable drugs, does serious damage to drug researchⁱⁱⁱ. While nobody would want to claim that the drug companies are populated by angels, parallel importation, especially as you practise it in Europe, would seem to put research at risk without even the short-term benefit of lower prices to consumers.

I say that because the evidence is clear that in Europe, much of the return from arbitrage (that is to say the money to be made from trading on the price differentials between different countries) stays with the parallel importer, and is not passed on to the consumer.

We should note in this regard that the system of parallel importing differs significantly between North America and Europe. It is not, as in North America, a matter of buying drugs in Greece and setting up a website offering to sell them to consumers in Sweden. *Parallel importers in Europe are regulated middlemen between pharmacists* who between them capture most of the economic benefit of the price differentials between countries, not consumers.

To understand why, it is helpful to think about because of the way the European drug insurance system is set up. Parallel trade has virtually no scope for saving consumers money, because in many countries consumers pay virtually nothing out of pocket, while in others, which use reference pricing, consumers pay only the difference between the reference price and the list price of the drug. In those countries, most consumers avoid paying anything by buying drugs whose list price is at the reference level^{iv}.

While neither the United States nor Canada have European-type universal drug insurance systems, the design of most private drug insurance in both countries is such that most *insured* consumers there are also equally insensitive to the full price of the drugs which they buy, so that there is virtually no price competition among insured drugs at the consumer level because consumers derive no benefit from comparison price shopping. Uninsured consumers are a different matter, to which we shall return below.

The benefits of parallel importation in Europe, then, go to the parallel importer and the pharmacist who buys drugs from a PI source rather than from the original manufacturer. How the profits are divided is a matter for bargaining, but in the documented case of one drug made by AstraZeneca, the company lost virtually all of its sales in its home market in Sweden to parallel imports of its own products from places like Greece. In that case, the drug company will have received only the profit that it made on the original, non-Swedish sale, while the profit that it would have made on the Swedish sale will have gone to the druggists and the parallel importer. In some countries the government cuts itself in on the deal, by funding the drug insurance system on the assumption that pharmacists will be buying some parallel imports. In the United Kingdom, for example, the NHS claws back part of the payment due to pharmacists (for drugs covered by the NHS) to reflect the level of parallel import products which it assumes that the pharmacist has bought. In Germany, pharmacies are required to buy a certain minimum percentage of parallel imported drugs.

So to sum up the European situation, parallel importing is a transfer of income from drug *companies* (who do the vast bulk of R&D and innovation, financed out of their cash flow which they derive from sales) to arbitrageurs and druggists, who do none. Because of the way the public drug insurance market works, it therefore saves consumers nothing, but harms drug innovation. You Europeans sure are clever, and have placed yourself in an extremely morally weak position to criticise America's efforts essentially to extend your parallel importing regime to them.

Perhaps you think, though, as the single market ideologues do, that price differentials between different countries for the same product are evidence of a poorly functioning market and arbitrage is therefore highly desirable? In many cases this analysis is correct and arbitrageurs increase the efficiency and transparency of markets. But not all price differentials are evidence of market inefficiency or even failure. Drug pricing is a good example.

What accounts for the fact that drug prices are different between Canada and the US, for example? Many people believe, for example, that price controls are the chief explanation of the price differential, but these people are almost certainly wrong. Different forms of government intervention certainly play a role, but it is **relatively** marginal compared to a couple of other factors: differences in standard of living between the two countries, and legal liability issues.

While our respective standards of living used to be quite comparable, for a number of reasons, Canada's has been falling relative to the US. Today the average Canadian has a standard of living (depending on how you measure it) that is 20-30% lower than the average American. That has consequences for this discussion. To understand why, we have to talk about what economists call price discrimination, or "pricing to market".

Basically, firms sell their product in different markets, and charge different prices on the basis of local market conditions, such as ability to pay. This is not only true between national markets, either. The fact that no two people may have paid the same price for a seat on the same airplane is also price discrimination, and is perfectly rational for both passengers and the airline in that it apportions the cost of the airline's operations, in a rough and ready way, according to the value of tickets to different types of consumers.

To come back to national markets, though, when a firm sells its product in two different markets, *so long as those markets are separate*, the firm will calculate a unique profit-maximizing price for each market. The general rule is that price will be higher in the market where consumers are less sensitive to price (i.e. the *amount* they buy will be less influenced by the *price* they pay). Low income markets tend to be more price sensitive, so prices will tend to be lower in those markets, so long as separation of the markets can be maintained.

A great many commodities differ in price across national borders. There is a reason why Canadians in many US border communities are known as *cheeseheads*. It's because Canadian government policy, for reasons too illogical to be explained to a rational audience such as this one, makes cheese hugely more expensive than in the US. Canadians, on discovering how cheap American cheese is, fill their boots on their way through, for reasons that must appear mysterious to many Americans.

Cars tend to be less expensive in Canada. Once the price difference reached a critical level, it became profitable for individuals to buy cars in Canada for re-sale in the US, to a degree where the auto companies began to take measures to prevent it, by refusing to honour warranties on cars purchased in Canada and re-sold in the US, for example.¹ On the other hand, with the recent dizzying climb of the value of the Canadian dollar vis-à-vis its US counterpart, some purchases have now become less attractive for Americans in Canada. Apparently cross-border purchases of pharmaceuticals is a case in point as purchases have declined with the value of the US dollar, which is eroding the Canadian price differential.

¹ . When the Canadian dollar was high against the US dollar in the mid-nineties, we had a huge trend to "cross-border shopping", where it was worthwhile for many Canadians to cross the border and do their shopping in the US, to the dismay of many Canadian retailers, who could not escape the higher costs of doing business in Canada. Had the dollar not fallen, you can be sure the government of Canada would have found new policy measures to maintain a higher degree of "market separation" because it was putting many bad government policies under increasing economic pressure.

There is no doubt that one of the major explanations of drug price differentials between our two countries is market separation to reflect the fact that Canadians cannot pay as much as Americans for their drugs. From an economic point of view, this makes perfect sense. Every separate market will have a profit maximizing price that represents that market's maximum sustainable contribution to the R&D effort of the pharmaceutical industry, as well as covering the hard costs of producing the actual medicines consumed. Thus markets do not necessarily eliminate price differentials which may well exist for reasons other than market inefficiencies. Indeed, in the case of drugs, the elimination of differential prices across markets almost certainly results in a *levelling up* of prices (thus harming those least able to pay) and quite likely a decline in revenue (and therefore R&D effort) by pharmaceutical companies, an outcome that is desirable from no point of view I can imagine.

The second big factor that explains cross-border price differentials and that has nothing to do with Canadian government policy is the US legal system. That system has a significant, and probably ultimately harmful, impact on the US market for prescription drugs.

Drug companies are favourite targets for American trial lawyers. They are not unique in this, of course. The entire US health sector is a feeding ground for trial lawyers. The US legal system in effect imposes a huge tax on pharmaceuticals that Canadians and Europeans do not have to pay.

One researcher looked at the role played by American liability rulings on the difference in pharmaceutical prices between Canada and the United States. He concluded that: "A large part of the observed variation in the price differential is attributable to anticipated liability cost, and liability effects explain virtually all the very big price differences observed. The best prediction of the model is that in this data set, liability risk roughly doubles the average price differential and increases the median price differential by about one-third." Rest assured that US trial lawyers are clever and inventive enough to find a way to use the US legal system to impose some of those liability costs on Canadian or European suppliers of drugs that have entered the US, with predictable effects on prices.

So the evidence shows that the price differential between Canada and the US is driven chiefly by market forces (in the form of market separation) plus the costs of US product liability policies. Canadian government price controls explain considerably less of the differential, but the precise proportions are a matter for further research.

Here is a further wrinkle. While I have no European research on this issue, there is really no such thing as the "American" or the "Canadian" price of a drug. Not only are there differences in price across national borders, there are also significant differences *within each country*. Within the US, for example, various groups, most

notably government agencies, have negotiated discounted prices with drug companies².

Even when we are looking at market-determined prices of drugs, we cannot really talk about a single “American” or “Canadian” price. For example, there are significant differences between market prices charged for the same drug by different suppliers even within the United States. One piece of research looked at the dispersion of drugstore prices of over 100 prescription drugs in two communities in upstate New York. The researcher found that, on average, the highest posted price for a given prescription is over 50 percent above the lowest price. This was among pharmacies so close together that, in one of the communities investigated, each of the town’s ten pharmacies was within a five minute drive of all of the others. Some U.S. states are setting up Web pages on which are posted the prices of drugs in different pharmacies. Taking advantage of that information, and buying more generic drugs, would go a long way towards cutting the costs of American health care.

But while these price differentials might spur consumer price comparison shopping if we were talking about televisions or MP3 players, they clearly do not in the case of drugs in America or, as we have seen, in Europe. Why not? As I’ve already suggested, one very important reason that drug prices in the United States are as high as they are is the completeness of the U.S. insurance system. When one only pays a few dollars for a prescription, regardless of what the full price of the drug might happen to be, one has no particular incentive to shop around, and suppliers have no competitive incentive to keep prices low. Research shows that drug companies *do* respond to consumer demand in setting prices, but that only happens if consumers have an incentive to respond to prices. No personal incentive, no comparison shopping.

This, then, is the source of much of the trouble in the U.S. market for prescription drugs. Drug companies set their prices at levels appropriate to markets in which the bulk of the consumers have insurance generous enough to make them insensitive to the full retail prices of their drugs. Those levels tend to be high. Insured consumers do not worry about this: the amount that they will pay out of pocket will be well below the full retail price of the drugs. People covered by government plans will also be protected, and probably will not be paying much out of pocket.

The uninsured, though, including those who are in jobs which pay too much for them to be eligible for a government program but which do not provide private drug insurance, not only have to pay out of pocket but have to pay the full market price. *The full retail price, in other words, tends to be paid out of pocket only by those consumers*

² Government pricing rules sometimes have unintended consequences. For example, Medicaid bases the price that it will pay for a drug on the average private-sector price for that drug. Those private sector prices will have been set at profit-maximizing levels, but when Medicaid is a large purchaser of a drug, drug companies have an incentive to raise the prices that they charge private-sector purchasers, even if that means losing some profit from those markets, in order to keep the Medicaid price high. The effect of the rule, then, is not to lower the price that Medicaid pays, but rather to drive up the prices that other purchasers pay.

who do not have insurance. These, for the most part, are the people looking to parallel imports from Canada, and now the EU, as a source of cheaper drugs.

Now that we have established the importance of insurance coverage and of market separation in drug prices, we can add another piece to the puzzle. You see, the demand for reimportation of drugs into the US flagged a year or two ago, but has resurged in the last little while. Why? Again it is driven by insurance considerations, but this time around the design of state-funded insurance coverage in the US. Recently the US government introduced the famous Medicare Part D program, which was aimed at giving retirees access to prescription drugs. In fact it clearly has improved access for a great many retirees, and the politics around drug coverage in the US quieted down as people worked with the new system. The renewed interest in reimportation is a direct consequence of what people have discovered about the strange design of Medicare Part D. I won't bore you with the details, but the key provision is this: coverage is fairly generous on the first \$2250 in annual expenditure on drugs. Once you breach that limit, however, you as an individual are responsible for 100% of the cost of your drugs until your total expenditure for the year passes \$5100. After \$5100, coverage becomes even more generous than before.

That \$2850 between \$2250 and \$5100 is what has come to be called the "Medicare doughnut hole", and it is that hole that is responsible for the revived interest in drug re-importation. It has been estimated that 7 to 10 million Medicare beneficiaries fall into the doughnut hole, but the ones who really matter, from the point of view of the re-importation debate, are the low income elderly with chronic illness. They are the ones who are now being encouraged to look to Canada and, eventually, the EU, for cheap drugs, and since their plight will make good TV news, we can expect it to spur an even stronger revival of interest in re-importation, especially since it is a Democratic Party issue and one that the new Democratic majority in Congress wants to use to show that they have advanced their voters' priorities since the last election.

Should Canadians and Europeans care if Americans ramp up the level of parallel importation? The answer is yes.

Given the right conditions, parallel imports can reach high levels. For example, parallel exports now amount to about 22 percent of the Greek pharmaceutical market^v, and that's just within Europe. This has raised concerns about shortages in Greece (just as there is concern that re-importation to the United States on a scale sufficient to make an impact on that market would result in shortages in the Canadian market). Swedish pharmacists also complain of shortages of PI drugs and unreliability of supply.

Evidence on shortages is to date anecdotal, but some drug companies have begun to restrict the quantity of drugs that they will supply to countries which are sources of parallel exports^{vi}. European courts have ruled that, while a complete halt to supplies would be grounds for compulsory licensing of the drug in question, drug companies are free to restrict supply to an amount consistent with the size of a country's

domestic market, so that any parallel exports would reduce the quantity of drugs available for consumption in the exporting country.

American drug companies have moved to restrict re-importation from Canada by refusing to supply any wholesaler who has sold to re-importers. Tight inventory control methods make it likely that, even if a complete cut-off of supply were not feasible,^{vii} oversupply by the companies would not be necessary, so that if a significant quantity of drugs was being re-exported from Canada, Canadians could reasonably expect to experience shortages in the domestic market. After all, being a drug company is not being a member of a suicide pact, and we can hardly expect them to stand by and see their business model undermined, no matter how US politicians try to legislate their behaviour even beyond America's borders, as the legislation currently before Congress offensively attempts to do (even though I doubt that the attempts to punish companies for their behaviour in this way will succeed). And the more successful parallel importing becomes in terms of volume, the greater will be the pressure on companies to find strategies to reduce supply to source countries.

There is already evidence that drug companies are engaged in non-price strategies to obstruct parallel trade in Europe, just as they are tightening supply to Canada and likely will do so to Europe if the Dorgan legislation passes Congress.

Since wholesale and retail margins are not subject to price controls in Canada, competition among retailers for the reduced supply of drugs could be expected to raise the price of drugs to Canadian consumers. Since most Europeans pay a state-determined price, the reaction here will be felt either in increased deficits, increased taxes, or reductions in drug benefits, or some combination of the three. Yet because the amount of drugs involved would be small relative to the total U.S. market (and because even if there were retail price controls in Canada, they would not apply in the United States any more than Greek pricing regulations apply in Sweden) it is unlikely that there would be any significant reduction in the American price. The likely outcome is disruption of our markets and of drug companies' R&D efforts and an enriching of arbitrageurs in exchange for little gain for consumers in the US.

So we are closing in on our conclusion, and I appreciate the fact that you have stayed with me throughout this long but indispensable chain of reasoning. From an American point of view there is an argument for drug re-importation as a second best solution to some American policy problems, and, among second best solutions, one which drug companies would probably not object to, although it would not be particularly politic for them to come out in favour of it.

The most pressing health care problem which the United States faces is the problem of the uninsured. Of course lack of insurance is not the same as lack of care when it comes to access to certain kinds of care, most notably hospital emergency room and clinic care, but it is true that in the case of pharmaceuticals, lack of insurance is likely to mean lack of care.^{viii} While there are some programs aimed at giving low-income

groups access to expensive drugs, there is no national program,^{ix} so the uninsured frequently end up being the only group actually paying full price for prescription drugs. Since many of the uninsured are low-income individuals, it is not unusual to find them priced out of the market. From the perspective of the drug companies, this is not a profit-maximizing state of affairs and from the point of view of those without access to drugs it can be a life-threatening or at the very least an economically disastrous situation.

But that doesn't mean that Europeans and Canadians should pay to fix America's feckless health care policies. That is for Americans to do. As I noted at the outset of my talk, America is mesmerised by its own problems, and what look like simple and cheap "solutions" to them are often costly headaches to those most affected by them.

I can't say that we in Canada should get too exercised about Americans driving across the border to have their prescriptions filled at Canadian pharmacies, or making purchases from the websites of legitimate Canadian pharmacies. The number of individuals whose insurance status makes that their best option for having their prescriptions filled will probably not be large enough to disrupt the Canadian market.

However, when American politicians start proposing that government plans and other bulk purchasers make large-scale purchases in Canada or Europe, we should be concerned about disruption to our own markets and getting caught in a power struggle between Washington and the drug companies in which the survival of those companies' business model and more importantly the pipeline of future pharmaceutical innovations is at stake.

We should also be concerned when American politicians start using re-importation of drugs as a political smokescreen. As Brian Ferguson likes to say, a policy of controlling U.S. drug costs by shipping drugs north to Canada and hoping that they will still be cheap when they come back into the United States is on a par with asking the tooth fairy to provide a national dental service on the grounds that it will be self-financing.

Not only would it disrupt our market, but by going along with it we would be abetting a fraud perpetrated on American consumers by American politicians. Re-importation is not a solution to the American no insurance problem, and our governments should make it quite clear that the costs to our consumers of large scale re-importation of pharmaceuticals by local and state government plans and the disruption of the business model driving drug companies' vital R&D efforts would far outweigh the benefits to American consumers. The Canadian government is already doing so by adopting legislation giving it the power to control pharmaceutical re-exports if they ever endanger the domestic supply of drugs and you should consider doing so as well if you have not already done so.

The United States needs to sort out its health insurance mess. Drug re-importation will not help, and it proposes to hold our consumers hostage to American politicians' pusillanimity. No pill will make this headache go away. The only solution is to go toe-to-toe with the Americans and make it perfectly clear to them, in the nicest possible way, that we will not allow our citizens to be used as pawns to allow American politicians to evade their responsibilities to their citizens.

But in the case of Europe, your voice would be clearer and more persuasive if you weren't already engaged in the kind of behaviour for which you now want to criticise Washington. The strongest and easiest to defend position is that parallel imports are misconceived and wrong in principle, not that they are good for Europeans, but bad if America wants to get into the game, which is the position you seem to be trying to defend today.

ⁱContrary to what's often stated, this isn't new: only the drugs have changed. In the earlier years of the modern pharmaceutical industry, profitability also depended on a handful of blockbuster drugs. In those days, the blockbusters were new antibiotics.

ⁱⁱIf, for example, they paid all of their retained earnings to shareholders as dividends and borrowed to finance research lines.

ⁱⁱⁱNow that India has signed on to TRIPS, and implemented product patents as opposed to the process patents which it recognized in the past, drug companies might be tempted to take advantage of the high quality of the scientific human capital available there to move some of their R&D activity to that country. There might also be cost savings associated with moving more of their operations to those Eastern European countries which have shown an ability to adapt to a market economy. As we noted earlier, the multinational drug industry has no significant problem relocating geographically when the incentives are right.

^{iv}Pavcnik (2002).

^vFor a summary of the institutional structure of the Greek pharmaceutical market, see Kontozamanis, Mantzouneas and Stoforos (2003).

^{vi}They already restrict supplies to low price countries when other countries use those low prices as the basis for setting their own reference prices. See Danzon (1998).

^{vii}Some of the U.S. legislation intended to legalize re-importation includes restrictions on restriction of supply. It is not easy to see how that sort of requirement could actually be enforced.

^{viii}We should qualify that statement by pointing out that about half of drug company marketing expenses is accounted for by the value of detailing - of free samples given to doctors. Most of those drugs will wind up being given to people without good drug coverage. Critics of drug industry advertising expenses should note that drug companies could slash their advertising expenses simply by not giving drugs away.

^{ix}It often comes as a surprise to Americans to discover that the same is true of Canada - many Americans, including American health economists and policy analysis, don't realize that Medicare doesn't cover prescription drugs and that we basically get our drugs the same way they do - through employer-based insurance topped off by a patchwork of special programs for individual diseases or groups.