to improve the safety of health IT systems. This is very important work that AHRQ looks forward to continuing, in close collaboration with the Office of the National Coordinator for Health Information Technology.

**JAMA:** The US House Committee on Appropriations has approved a draft 2016 budget for Health and Human Services that would terminate funding for AHRQ. That happened in 2012 and AHRQ survived. What’s your take on how you’re in the same place again, and what do you see as the way forward?

**DR KRONICK:** My job as director is to try to explain as clearly as I can the work we do and the value of that work. The appropriated budget of the agency is about 1/100th of 1% of national health spending. The return on investment from this 1/100th of 1% is very large, as evidenced by recent reports on quality of care and patient safety. I am confident that if more money were devoted to trying to figure out how to improve the delivery of care, the return would continue to be extremely large.

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**The JAMA Forum**

**Probing Our Moral Values in Health Care: The Pricing of Specialty Drugs**

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Imagine visualizing a health system through the eyes of an economist in the form of a supply curve, which shows the relationship between price of a product or service and the quantity of product that a seller can offer. In this example, the seller is the health system, a large agglomeration of highly skilled professionals supported by sophisticated technical equipment and institutions. The “product” being offered to society is the benefit of interventions in terms of the quantity and quality of life it generates, measured in quality-adjusted life-years (QALYs) ([http://bit.ly/1L3Tv6h](http://bit.ly/1L3Tv6h)).

Through some interventions, such as immunizations or maternal health care, physicians can wrestle some additional QALYs from nature at very low cost (see point A in the Figure). Other QALYs can be obtained only at enormous incremental costs per QALY (points above B in the Figure), such as additional months of life achieved with high-priced specialty drugs during terminal illness. Cost-effectiveness analysis can determine that one treatment is not cost-effective, because the same additional QALY can be achieved with a lower-cost treatment (points X vs Z in the Figure).

The health system’s QALY supply curve confronts society with 2 vexing moral questions that physicians are not in a position to determine on their own. First, how much is society willing to pay for an additional QALY derived from a particular intervention? And second, should the maximum price to be paid per additional QALY be the same for everyone, or can it vary with the individual patient’s ability to pay for it?

The answer to the first question requires putting a dollar value on a QALY, to determine whether the cost of the treatment used to “purchase” an added QALY from the health care system is justified. The answer to the second question reveals the distributional ethic to be imposed on the health care system: either rationing access to high-priced specialty drugs by income class of patients, or following a more egalitarian approach expressed through collective decision making.

Currently, the median household income of Americans is roughly $52 000 ([http://1.usa.gov/1Tr8E3z](http://1.usa.gov/1Tr8E3z)). Therefore, in the absence of health insurance, only a few members of society could afford the high prices now routinely charged for new specialty drugs. The maximum price of a QALY would be severely constrained if these products had to be purchased strictly out of household income. To be affordable to those without health insurance, the high cost of these products could not prevail. Absent health insurance, the now-high rates of return to investment in developing these products would be much reduced, and many of these drugs might not even be developed.

However, because the majority of US households do have health insurance coverage, the problem of putting monetary values on QALYs is deflected away from individual households and onto the administrators of public or private health insurance funds. Those administrators face the morally difficult question of what value their funds should be willing to put on an extra QALY purchased for its insured members with new specialty drugs.

Knowing the reluctance of US consumers even to discuss such morally vexing questions ([http://bit.ly/1DLba2C](http://bit.ly/1DLba2C)), the producers of specialty drugs are now crawling up higher and higher along the steeper segment of the QALY supply curve, exploring whether there is a maximum price per QALY that US consumers will tolerate and what that price may be.

One should not question this pricing policy on moral grounds. After all, for-profit producers of new medical technology generally have been set up as practitioners of Anglo-Saxon capitalism ([http://bit.ly](http://bit.ly)).
These enterprises will thus naturally seek by any legal means the maximum revenue for a new product. This usually includes the practice of profit-maximizing price discrimination, which means charging different prices to different customers for identical items with identical production costs. The investor-owned producers of new specialty drugs properly call this approach “value pricing,” because it is based on their subjective estimate of the maximum value society imputes to the added QALYs these products can produce.

But in pursuing their pricing strategy, specialty drug producers should not imagine themselves as free-enterprisers operating within the competitive markets of textbook fame. On the contrary, we can think of them as fragile little birds that the protective hand of government carefully shields from the harsh vagaries of truly free, competitive markets. That protective hand consists of patents granted these producers by the US Patent and Trademark Office and market exclusivity that can be granted by the US Food and Drug Administration on request. It also consists of prohibiting resale of these products among customers, such as reimposing drugs from countries that have been granted lower prices.

When the government grants private investors the monopoly powers extended to the producers of specialty drugs, it has the right and the duty to monitor and possibly regulate what these investors do with that privilege, including their pricing policies. The government has to be mindful of the social opportunity costs of high health care spending, which means beneficial activities such as education and infrastructure that are displaced by high spending on health care.

The social opportunity costs of high drug prices depend heavily on the incidence and prevalence of the disease being targeted by a drug. For a genuine orphan drug that could benefit only a small number of patients, a high price would have only a small effect on total health spending (although its cost would be devastating for an uninsured individual unless that person received financial assistance to acquire the drug).

For a drug that could benefit many patients, however, a high price for that drug can have a sizable effect on total spending (http://bit.ly/1DLbRJh) and hence on health insurance premiums, as is the case with the hepatitis C drug SOVALDI and likely for the newly approved cholesterol-lowering pro-protein convertase subtilisin kexin 9 (PCSK9) inhibitors.

The government faces a tricky trade-off in bringing countervailing power to the market for specialty drugs, weighing the social opportunity costs of ever-higher health spending vs the reality that prices of new drugs should be high enough to encourage private investors to foster medical innovation. Investors’ compensation should help them not only recover their outlays for developing new products but also include a premium for assuming the financial risk that such investments may not pay off.

A lively debate can be had over how high that compensation for financial risk should be. When considering the financial risks of investors, one might gain some perspective through contemplating how we compensate others who assume risk on society’s behalf, such as police officers, firefighters, or members of the armed forces. A good start in that regard might be perusing images of the horrific wounds in the first chapter of the US Surgeon General’s monograph on Combat Casualty Care (http://1.usa.gov/1gxJSRN), and contemplating the truly moderate premiums we pay young men and women in the armed forces for assuming those risks on society’s behalf.

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