THE LAURA FLANDERS SHOW

AMERICA'S DRUG PRICE NIGHTMARE: PUBLIC PRODUCTION CAN SAVE LIVES

LAURA FLANDERS: Today we bring you a story of possible progress tackling America's killer drug price problem. If you or someone you care about depends on a life extending drug, you know exactly what we are talking about. American diabetes sufferers, for example, number in the millions, some 37 million, or close to 15% of all American adults. Diabetes is the eighth leading cause of death here. A drug we call insulin can save lives. It's readily available. It was discovered over a hundred years ago. But as we entered this decade the price of commercial insulin was hovering at an astronomical $300 a dose. It's not the same elsewhere. According to the Rand Corporation, Americans spend more on prescription drugs per capita than citizens in any other country. Some $1,200 per person in 2019. So what about that progress I mentioned? Well, building on a deal struck for Medicare recipients, the Biden administration this spring announced an agreement with manufacturer Eli Lilly to cap insulin prices at $35. That's a step, but what would really make a difference would be to get private profit and monopoly patents out of the health business altogether. And there's plenty of movement in that direction internationally and some exciting moves coming out of California. More on that in just a bit with our guests. Dana Brown is Director of Health and Economy at the Democracy Collaborative, where her research focuses on health and care. She's the author of "Medicine for All, the Case for a Public Option in the Pharmaceutical Industry". Luis Gil Abinader is a legal scholar and fellow at the Georgetown Law O'Neill Institute, who spent over a decade working with civil society organizations in global campaigns seeking access to medical technologies, including Covid-19 vaccines and treatments. Kevin Wren is a volunteer patient advocate and chapter leader of California #insulin4all and T1International, a group run by and for people with Type 1 diabetes. He's an insulin taker and one time rationer and he is far from alone in that. Dana, as our kind of big picture person here, did I get the facts more or less right there, about the big story on this problem?

DANA BROWN: Yeah, well I think the problems are multiple, as you said. We live in the richest country in the history of the world, yet diabetics and many other patients suffer without access to medicines that are actually fairly easy to make and that have been around for a long time. And so, I think the conclusion that many of us have come to is that medicine as a profit center, as a part of our economy that is built to benefit the few, that is CEOs and a few shareholders, maybe isn't the best model. And that there are other models that could be built from the beginning to produce and deliver and distribute medicines in the benefit of us all. And that's why we work on ideas around a public option in pharmaceuticals for the development and manufacturing of medicines because it would be good for us all, in terms of medicine prices, but also there's a lot of other effects for society in terms of, you know, having an ownership stake in the economy.

LAURA FLANDERS: Kevin, you're someone that depends personally on that medication.

KEVIN WREN: Yeah, so I was diagnosed with diabetes in 2001, when I was 15. I rationed when I graduated college and I aged off my parents' insurance like many have done. Nearly one in four in the US has rationed.

LAURA FLANDERS: When you say rationed insulin, you mean not taking your full dose, the dose that you actually need to stay healthy?

KEVIN WREN: Yeah, so taking basically a half dose, so extending the life of your insulin and the vial twice as much by taking half as much.

LAURA FLANDERS: How much was it costing you at that point?

KEVIN WREN: At that point it was maybe, I was paying $300 out of pocket just for my insulin. That's not the supplies. And I was cutting it as long as I could. I was juggling my rent, I was juggling food. When you're rationing insulin, you're rationing everything else. So it's a nightmare.

LAURA FLANDERS: Luis, turning to you, given what you've just heard from Kevin, what's your perspective, especially coming from where you are in the Dominican Republic?

LUIS GIL ABINADER: Yeah, I mean just like people in the United States struggle to have access to health products like insulin or you know other types of treatments, people around the world face the same type of challenges. Drug prices around the world tend to be high and that prevents people from having access to those treatments and vaccines and therapeutics.

LAURA FLANDERS: You're actually in DC, but you're from the Dominican Republic, and you litigated a crucial case there that came out of the Covid-19 pandemic. Can you talk about your battle with Pfizer over Paxlovid, the Covid drug?

LUIS GIL ABINADER: Yeah, so last year in the Dominican Republic, we asked the Dominican government to expand access to this oral antiviral for Covid-19 named Paxlovid. And we asked them to use this legal permission that they currently have, that is recognized in the constitution to break the monopoly that Pfizer has and Pfizer sent their lawyers and opposed the request that we were, that we filed saying that the Dominican Republic, if they did this measure, if they implemented this measure to expand access to a drug in the middle of a pandemic, that would be a violation of Pfizer's "human rights". They actually said that. So the Dominican government eventually recognized that they have the legal power to break Pfizer's monopoly, but

they said, we're not going to do it. And the reason why they did that, you know, in my conversations with government officials there, is because they don't want to go against the immense power that Big Pharmaceutical corporations have. And so when we're talking about, you know, Big Pharma and public pharma manufacturing, what we're talking about is measures to limit the immense power that these corporations currently have.

LAURA FLANDERS: And we should say the corporations like these have the power not just to bring drugs at affordable prices, but jobs, locate businesses, manufacturing, I mean this is true across the region. What did you learn from that experience?

LUIS GIL ABINADER: Well I learned, that we need to implement measures to limit it, to create alternatives to the idea that only Big Pharmaceutical corporations driven by profits and governed by shareholders should be the one deciding who manufactures vaccines and treatments and other type of health technologies, where, and at what prices, that the current model is not working for the people. It's not ensuring access to the people.

LAURA FLANDERS: There may be people watching and listening who say, wait a minute, I thought if this, I thought patents only lasted for a while. The corporations only get to own a private patent for so long, if this drug's been around for so long. Let's just talk about insulin for a minute. Why are we still in the clutches of Eli Lilly? Or in the case of Paxlovid, Pfizer has many patents that extend over decades. How come, Dana?

DANA BROWN: Part of it does have to do with power and the fact that, you know, the institutions and the laws in our society have been set up to benefit corporations first and foremost. So it, Luis can give us further detail about patent law, but really what we've learned as patients and as citizens is there's a lot of ways for corporations to sort of game the system to get a patent and then find ways to extend it and extend it, to make some small tweak in the delivery mechanism or the flavor or the color of a drug and then say this is new and innovative, give me a new patent, and extend their property rights and their ability to then charge monopoly prices over these lifesaving medications through that process. The big point for us is that it doesn't have to be that way. I mean historically there was a long chunk of history where in most countries, you couldn't patent chemical compounds, much less medicines. And it's not like there wasn't drug innovation then. So I think we just need to think about medicine in a different way and insist as a society that our government, which supposedly represents us all, do much more to free us from the clutches of this monopoly power and assure they're providing medicine as a public good.

LUIS GIL ABINADER: So that is a positive step, but the core of the problem is the monopoly. We give pharmaceutical companies, Big Pharma, the ability to control the technology and therefore, the ability to decide who gets pharmaceutical products, vaccines, treatment, insulin, and at which prices.

LAURA FLANDERS: Now there is, as I said at the top, some international movement on this and a group that you all are familiar with, and Kevin, I think you work with T1International, has been in some ways leading a charge. Can you tell us what that organization is and can you explain its name to begin?

KEVIN WREN: Yeah, so T1International is an international organization by its name, started as an organization to support Type 1 diabetics, but we're more inclusive to include all people with diabetes and want to encourage access to insulin and all the things that we need to survive. We need supplies, we need access to care, and it's an international movement. But here in the United States, it started maybe five years ago, and has really led the way in establishing co-payment caps for insulin, setting up patient coalitions, and then also passing this California legislation that would allow the state to manufacture insulin.

LAURA FLANDERS: When I saw the news, when I heard about Gavin Newsom's press conference, you know it's Gavin Newsom, I know there are always devils in the details, but it's a huge step in the right direction and it is very exciting model for the nation.

KEVIN WREN: There are over 3.4 million in California with diabetes. So if we can lower the cost of insulin by producing it at a fraction of the cost, which is around $30 is what they want to offer, that is a steep discount from what it is at the list price. So with 3.4 million using insulin, I mean that's, yeah.

LAURA FLANDERS: It would make a big difference to you and 3.4 and a bit million other people. Dana, to you, can you just underscore for people here who perhaps are unfamiliar or less familiar than they should be with the whole concept of public ownership, what makes that structure different?

DANA BROWN: So what's happening in California is categorically different, right? Because there's no profit motive here, there aren't shareholders, there's not a CEO in some other country who's making a lot of money for this. The public sector is going to be producing or entering into contracts to produce insulin at cost or at a little bit more than cost to begin with. So no one's paying this extra amount of money to satisfy Eli Lilly or Sanofi or another corporation. And we as a society benefit, I'd also just like to underline that there are huge benefits for everyone. It's not only important to me as an American, that Kevin because he's a great person, gets his insulin, right? But it's actually important as a taxpayer and a human that millions of people get to participate in the workforce and that's also helpful, they pay taxes, right? People get to go to school and participate in their communities. This has economic and social benefits for all of us. And last thing, having the public sector take a bigger role in the production and distribution of medicine, categorically starts to shift the balance of power. With some of the examples that Luis

brought up earlier, governments are often reluctant to take any action to regulate Big Pharma, for fear that they're just not going to bring new drugs to market or right, they're not going to cooperate with us. And the only reason that that works, is because they're the only game in town. If Big Pharma are the only folks making drugs, then they have all the leverage. Once the public sector is also making drugs, that starts to rebalance things and erode some of their regulatory capture and open up policy space for other reforms, like price transparency and negotiating prices and all of those things.

LAURA FLANDERS: How common is this outside of the United States, Luis?

LUIS GIL ABINADER: We have seen a number of different public pharma initiatives in countries like Brazil, Sweden, you know, Cuba, and several others. In Cuba, they have the ability, not just to manufacture things like vaccines, but also to do the research in the development. And we saw that during the Covid-19 pandemic, where the Finlay Institute and the Center for Engineering and Biotechnology in Cuba, both of them, each of them, launched their own COVID-19 vaccines. And so because of what we saw during the Covid-19 pandemic, with vaccine inequity, what we are seeing is an increase in this type of initiatives where governments say, we're not going to just rely on Big Pharma to get our vaccines and treatment. We're going to produce it ourselves with public funding and with sovereignty. And so for example, now Columbia, which 20 years ago had the ability to manufacture vaccines, but stopped making those investments, stopped sustaining those public manufacturing capabilities, because of neoliberal policies. They have realized that, not sustaining that manufacturing capacity was a mistake. And so now they are creating in the city of Bogota, the facilities to manufacture vaccines and other treatment, now with the support of the federal government.

LAURA FLANDERS: Has the IMF that imposed a lot of those neoliberal structural adjustment programs on countries like Colombia changed? Is it singing a different tune, Luis?

LUIS GIL ABINADER: Many international organizations are now realizing that, you know, the idea that developing countries should do like agriculture or textiles, and rich countries should control the technology. I think across the board, we're seeing international organizations realizing that that was a mistake. And also governments in the Global South are realizing that not sustaining their manufacturing capacity for things like vaccines is a mistake, because you must have access to this type of product and especially during health emergency, you cannot rely on Big Pharmaceutical companies that are driven by profit and governed by shareholders.

LAURA FLANDERS: Kevin, coming to you, Luis, conveniently mentioned Cuba, which reminded all of us I'm sure of the backlash that's likely to come knocking at Gavin Newsom's reelection campaign, it's socialism, it's anti the private profit motive, and it's of course stepping

on the private rights and freedoms of private corporations. How important is this moment to that confrontation?

KEVIN WREN: I think the opposition is purely free market capitalists that are just cutthroat and want to exploit the system. When this bill originally passed in 2020, it passed 31 to 8. So this is a bipartisan effort. In Washington state where I'm from, we passed insulin copay caps almost unanimously. There was one abstention.

JAY INSLEE: This is going to help so many people.

KEVIN WREN: This is a bipartisan issue and an apolitical issue too. I mean these are drugs that need to be regulated, like the utility, because they offer so much utility to people like me. Roughly 10% of the population has a chronic illness and they're exploiting and extorting our need for this drug. And it's coming to an end.

LAURA FLANDERS: We produce this program with no money from private pharmaceuticals companies, but boy, there's an awful lot of private pharmaceutical Big Pharma money in media these days. Dana, coming to you, you touched on the democracy questions early on, as did Luis, what's the Biden administration and what's Gavin Newsom up against?

DANA BROWN: You're right that it makes sense to expect backlash in the current kind of political climate that we're in and also given the power of Big Pharma. But to echo Kevin, you know, A, this is a pragmatic solution, that I think is really bipartisan in nature and the people that conveniently say, oh, it's California, therefore it's a radical thing. But you have to remember the state of Massachusetts has been producing vaccines and other biologics, biologic drugs in the public sector for over 125 years. The state of Michigan used to do it in the public sector. Their lab was privatized in the nineties. But now there's a resurgence of interest from a Republican state senator, who's been talking to the Democratic governor, about reviving that tradition of producing drugs in the public sector. So A, this is a tradition in the United States. We've developed and produced medications in the public sector at various scales, from small public health labs at the municipal level, to nationally under the Department of Defense. And this has been going on for a century or a century and a half. So really we're actually just relearning how to do something that we already knew how to do as a country and in terms of how can the public support, I mean follow the #insulin4all folks on Twitter and social media. They will keep you focused on the prize. And really, I think too, we just have to remember right, that we are, "We the people", right? And the public sector belongs to all of us and it's just our job to help remind it that it's supposed to work in our interest.

LAURA FLANDERS: On diabetes, we know that there are racial and regional and environmental aspects to who is most vulnerable. I think no group in this country is more

vulnerable to diabetes than Native Americans. Is that on the horizon, Kevin, getting closer to stopping this disease?

KEVIN WREN: No, we're no closer than we were when I was first diagnosed. I think even the developments with CRISPR are still long off. We've sunk a lot of research into a cure for diabetes and we have left behind the people that just need it. The ADA and the JDRF, taken millions upon millions of dollars and are funded by pharma, yet have remained silent on this crisis until just recently. So that's why the #insulin4all movement has really emerged is because we need a conflict free leader in insulin space and someone to fight for us. And that's why it emerged. But I think, I mean, diabetes rates are only increasing. You look at the data last five years, it's increased, I think like 2.5% here in California, and that's hundreds of thousands of people just in California. And you spoke about BIPOC communities. They're most at risk for rationing, just because of the inequities in our healthcare system. So we see the big picture about the inequities of our system, it really trickles down to people with diabetes.

LAURA FLANDERS: Luis, I've heard you say, that our approach to medicine needs to be decolonized.

LUIS GIL ABINADER: That is correct. Our current model for vaccine research development and distribution globally is colonial, in many ways, because Big Pharmaceutical companies have the ability to decide who gets vaccines and treatments and insulin and other pharmaceutical products and when and at which prices. And so low and middle income countries, the Global South, often relies on donation-based approaches to get their vaccines and their treatments. And often times those donations are for political concessions. We saw that during the Covid-19 pandemic with vaccine nationalism and vaccine diplomacy. So public pharma initiative, they have the ability to give resilience and sovereignty to countries in the Global South to avoid, to dismantle the dependence from Big Pharmaceutical companies.

LAURA FLANDERS: Coming to you, Kevin, maybe one of the strongest arguments for public ownership is that the people who came up with many of these drugs believed that they were coming up with a gift, I think as the originators of insulin put it, for the nation, for the world. When you look back to that time and speak to those people from this one, what do you say?

KEVIN WREN: I think their vision has been corrupted by the influence of a capitalist system that exploits and extorts disability. I don't think they could have foreseen that when they developed insulin and sold it for a dollar, that it would wind up in the hands of profiteers, because that's what they are. I think we've seen this in the last 30 years. The price has increased 1200%. A compounding annual growth rate of 8% for insulin in like the span of 20 years, means that it explodes in price. It costs $5 to make, it winds up costing over $200. And I'm tired of watching my friends die. I'm tired of hearing about people who ration. I'm tired of breaking the

law to help people source their medications. It's illegal for me to provide someone with insulin who is rationing. So I constantly am breaking the law just to help somebody just like me. I'm really tired of hearing the fears of children that have lived through those kind of fears. Yeah, it's tough. And I know that they would be disgusted. I know they would, they would fight like hell to like not give up that patent.

LAURA FLANDERS: Final word from you, Dana.

DANA BROWN: As I always say to people, we really need to make sure that our demands are as big and as bold, that they're commensurate to the magnitude of the problem we're up against and we're up against a lot. So I guess, I just always leave folks with, don't stop asking for the big stuff, because that's what we need as a country.

LAURA FLANDERS: And maybe we are making a little bit of progress here, but we need much more, thank you all. Dana, Luis, Kevin, it's been great to have you. Thanks for taking the time to talk with us today.

KEVIN WREN: Thank you.

DANA BROWN: Thank you, Laura.

LAURA FLANDERS: I hope you enjoyed that conversation about the possibilities of publicly owned pharmaceutical manufacturing. It's just one of the ideas that spreads when people get to hear about it. It's the kind of programming we seek to bring you on a regular basis here at the Laura Flanders Show. And every so often we can talk to you about real impact. Remember a program we did a year or so ago from North Carolina about the expansion of private for-profit paramilitary training camps. Well, that story in our reporting on it has led to a lawsuit brought by the residents of that small African American majority town called Hoffman, against that private facility, and the mayors who gave the go ahead in the planning process. A lawsuit is now going forward that may contest the kind of trauma that the residents have been enduring and air a whole lot more about what's going on in their backyards. It's part of the product of programming like this, that spreads ideas and possibilities and airs wrongs that just can get righted. I want to thank all of you who supported our recent pledge drive and if you want to find out about how you can participate in this project yourself, check out all the information at our website. Don't forget, you can always subscribe to the free podcast too. The information is right there. 'Til the next time, stay kind, stay curious, and thanks for joining me. For the Laura Flanders Show, I'm Laura. For more on this episode and other forward thinking content, subscribe to our free newsletter for updates, my commentaries, and our full uncut conversations. We also have a podcast. It's all at lauraflanders.org.