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Pricing the EpiPen: Drug Prices, Corporate Governance, and the Financialization of Biomedicine

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By Danya Glabau

Why does Mylan's EpiPen cost so much?

That was a question many parents of food allergic children found themselves asking this past August, as a flurry of news reports revealed that the standard two-pack now costs patients as much as $600 out of pocket. The device, a type of epinephrine auto-injector, looks like an oversized marker. Inside is a mechanism that pops out a short needle and delivers epinephrine in three seconds or less when it is pushed firmly against one's body (preferably the outer, upper thigh). Epinephrine – a hormone also known as adrenaline – is the preferred substance for halting and reversing a severe allergic reaction, called anaphylaxis. Originally created as a tool for delivering emergency nerve gas treatment on Cold War-era battlefields, the device is now considered a necessity for people with food allergies.

The EpiPen pricing controversy is one of many events that have drawn attention to the escalating price of medical objects and procedures in the past year. Turing Pharmaceuticals' Daraprim pricing scandal beginning in the fall of 2015 (about which I've written previously for Somatosphere) and Theranos' meltdown earlier in 2016 on the news that the high-priced tests they performed were not as advertised has kept the issue of high drug prices in the public eye. In the EpiPen pricing case, many journalists and members of the food allergy community have critiqued the credentials and motives of Mylan CEO Heather Bresch. From analyses of her possibly fraudulent MBA to critiques of her compensation to her political connections via her US Senator father, her rise to corporate stardom on the strength of EpiPen revenue has been put under the microscope.

One thing that sets these scandals about the costs of medical care apart from previous debates (such as those surrounding the cost of health insurance in the wake of the Affordable Care Act) has been the attention paid to *specific* pharmaceutical companies and their *specific* pricing strategies. In each instance, the CEO of the company has been placed in the spotlight, portrayed as both the representative for the complex

goings-on within their companies which generate such pricing strategies and an avatar for corporate greed in healthcare. Yet while blaming the CEO satisfies the forensic itch of reporters and congresspeople, it obscures some important structural issues at play in healthcare today. In particular, the methods now used to raise operating capital and bring new products to market have made healthcare CEOs increasingly beholden to a new set of actors with new expectations for company conduct and performance: shareholders, debt-holders, and various types of private investors.

An increasingly important part of research and development for most pharmaceutical companies in the past several years has been to outsource much of the clinical development and manufacturing research to smaller pharmaceutical, biotechnology, medical device, and health technology companies. Small companies conduct the early stages of research and development before their successful “assets” (as new products are called) are scooped up by larger ones via partnerships or acquisitions. These transactions reduce a pharmaceutical company’s infrastructural investment at earlier stages where technologies are more prone to failure due to rocky transitions to use in humans or persistent difficulties in producing the actual drug substance or device. By relying on investors and financiers in new ways to acquire so-called “de-risked” technologies, companies seek to reduce their exposure to the risks of conducting research on and designing products for unruly human bodies.

To attempt such transactions, companies need access to capital, and there are two ways for them to get it: sell more products, or sell them at a high enough price to generate revenue quickly and have cash on hand; or (as Karen Ho (2009) has also explained in her ethnography of investment banking) raise the stock price, which raises the financial valuation of the company (also known as the market capitalization, or market cap), which the company can then borrow against through investment banks and shadowy private equity firms. Mylan’s August 2016 quarterly financial statement bears witness to this strategy, showing that the company raised over $6 billion in capital through debt and stock issuance – essentially borrowing from investors against the promise of future stock price growth – between August 2015 and August 2016. This was almost the precise amount needed for the $6.6 billion takeover of Swedish pharmaceutical company MEDA and associated transaction costs.

EpiPen pricing policies were undoubtedly a crucial lever that enabled this particular transaction. The value provided to a company like Mylan by a device like the EpiPen is not only the value of the revenue collected to date, but also the demonstration of the company’s ability to continue to increase revenue through price increases and increased sales into the future. The promise of increasing revenue draws in new investors as the

strategy is demonstrated to work in successive quarters, increasing the company's stock price and thereby increasing the company's access to borrowed capital. For modern pharmaceutical companies, this promissory function of pricing is an important aspect of company strategy that enables the pursuit of other activities and transactions.

This episode concerning EpiPen prices – a snapshot in my larger, three-year project on food allergies in the United States – underscores the importance for anthropologists and STS scholars to do more rigorous research on the relationship between medicine and finance. (Notable, Somatosphere has already begun to feature such work in progress.) A number of scholars in what is often referred to as the social studies of finance have now studied how Wall Street-style investment banking gets done in practice (Mackenzie 2006, Riles 2011) and the distinctive cultural attitudes towards risk and reward these practices produce (Ho 2009). Meanwhile, medical anthropologists have written extensively about the construction of consumer and provider markets for pharmaceuticals (Dumit 2012, Greene 2014) as well as how clinical research is strategically designed to provide evidence for lucrative indications for prescribing (Petryna 2009, Jain 2013) and providing hands-on care (Kaufman 2015). What is missing in these literatures as they stand today is an in-depth understanding of *the financial practices of healthcare companies* and the effects they have on patient care.

These practices matter because they undermine what most assume to be the social role of pharmaceutical companies to be: the development of reasonably priced, high-quality medications for very ill patients. They do so by reinforcing the alignment of management with investors who are interested in making products with large markets that can quickly generate revenues that increase quarter after quarter, thereby generating revenue, increasing share price that can be leveraged as debt in exchange for more capital, or both. In the wake of the shareholder revolution and the widening acceptance of Wall Street financial governance models in healthcare-related businesses, the CEO's role in pharma has been redefined as one of keeping investors satisfied by assuring them that they will receive their anticipated returns. CEOs who fail at this can be removed by their company boards, as it is not uncommon for the majority of a pharmaceutical company's board seats – especially those of smaller or new companies – to be populated by representatives of their largest shareholders. The company must be aligned with investor expectations from the top down for the work of making medicines to even begin.

I argue that it is a dead end to try to understand pharmaceutical company behavior – from pricing schemes to early-stage R&D strategies – based on the assumption that drug makers are primarily motivated by a desire to expand access to necessary care. This assumption, which I call the "care

thesis of biomedicine," makes pricing controversies seem contradictory, immoral, even irrational to observers (also see Dingwall 2016 for the impact this has within the medical profession). Understanding the financial entanglements of the modern pharmaceutical company with the financial sector, however, casts a different light on these controversies: they are perfectly rational when measured by the standards of the actors who control the purse strings. In other words, like any actors in ethnographic research, pharmaceutical companies make more sense when apprehended on their own terms. And it is those very terms – what I refer to as the *logic of finance capital* – that set companies down the path of what many analysts, reporters, and members of the public see as bad behavior that inflicts harm on patients.

Danya Glabau recently received her PhD in Science and Technology Studies (STS) at Cornell University. Her dissertation examined the culture of food allergy activism in the United States and drew on over two years of multisited ethnographic research. She is currently Faculty at The Brooklyn Institute for Social Research *and has worked with three New York-based biotechnology companies in the allergy space. You can check out* her blog *to learn more about her research, upcoming class at the Brooklyn Institute, and other events. You can also follow her on Twitter at* @allergyPhD*.*

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