The great American drug shortage isn't an accident, it's artificial (from Organized Money)

Dan: Hey there -

We've got kind of a follow-up here — to the series we just finished, about prescription drugs.

Through that whole series, we stayed super-focused on one thing: HOW to get the medicine you need — for prices you might be able to afford

— patches and workarounds for this broken system.

And we mostly held ourselves back from talking about — the System Itself.

We've talked before — we will again — about WHY meds are so expensive.

About the role of pharma companies — and of middleman entities called pharmacy benefit managers.

But it turns out: there's another set of players in this system … we've never looked at.

They have a role in ANOTHER reason you may not be able to get the drugs you need.

Some of the most important, life-saving drugs — they're in SHORTAGE.

And those shortages, they aren't an accident. They're the result of a monopoly.

So this story comes from our friends Matt Stoller and David Dayen (Day-en) at the podcast Organized Money - it's a show all about monopolies.

They're going to pull back the curtain on the world of drug distributors.

They'll show us how three powerful companies grabbed control over 90% of America's pharmaceutical supply chain — and created an artificial crisis.

It's a crisis that can be life or death for patients.

This story first came out last December— so, AFTER the presidential election, but BEFORE the new administration took office.

The Trump Administration has been talking about big tariffs on imported drugs.

Which experts say could raise prices — and, yes: create new shortages.

Meanwhile, these three companies will keep their grip on drug distribution. And this story will stay relevant.

I think you are going to really enjoy this episode— these Organized Money guys, they're pretty great —

And we'll be back in a few weeks with a new episode of An Arm and a Leg.

Till then, take care of yourself.

David: Some of the biggest secrets in the world. You always say they're found in books, but they're also found on government websites. If you go to the website of the food and drug administration, they have a site called FDA drug shortages routinely. Anytime you go to this, you will see this massive list. Well, I'm just going to start reading it.

Albuterol sulfate solution, amethystine injection, amino acid injection, amoxapine tablet, amoxicillin powder, amphetamine aspartate monohydrate, atropa belladonna, atropine sulfate ingestion, azacetidine injection. That's just the A's there are hundreds of drugs that are in shortage right now at so much so that the government has noticed

News Clip: "The Food and Drug Administration announcing a nationwide drug shortage. As the number of bacterial infections increase, the antibiotics we need to fight them are getting harder to find several.(fade)]

Matt: It's becoming a theme of organized money to talk about shortages and also to talk to business people who are competing and trying to fix the problem.

David: It's a, it's a theme of organized money and it could be like a subheading of the show, the story of shortages, uh, because you know, I was always taught that in, in a society that has abundance, where there's always going to be some supplier who will pop up to handle any problem.

This is the capitalist paradise we were promised. But what we find when we talk to people about these shortages is that the problem is actually very, very Soviet.

Matt: Today, we're going to talk to an entrepreneur and a lawyer in drug distribution, and he's going to explain how drugs are made, shipped, moved, and priced, and why there are so many shortages, particularly among the cheaper drugs, or you wouldn't expect it.

David: And it starts with the big three, another theme of organized money. These are companies you probably haven't heard of. There's Amerisource Virgin, which is now called Sancora, Cardinal Health, and McKesson, who run Most of the industry. And as we'll learn, they actually help cause the shortages.

Matt: And though you haven't heard of them, they are massive companies.

McKesson is the ninth largest company in America by revenue with 276 billion a year, which is about the size of Finland's economy. Sankore is 10th, Cardinal is 14th. Those are a little bit smaller, about the size of Hungary's economy. That's the country, Hungary.

David: Well, it seems like we should know more about how they work.

Uh, and Tim Ward, president, chief legal officer of Hercules Pharmaceuticals is going to tell us all about it. Let's get to it.

I'm David Dayen. I run the American Prospect magazine.

Matt: And I'm Matt Stoller. I write about monopolies in a newsletter called Big, and I'm the research director for a think tank called the American Economic Liberties Project.

David: On Organized Money, we're going to go beyond supply and demand curves and odes to visionary entrepreneurs and tell you how the business world really works.

Matt: We'll talk to business leaders, journalists, policy makers, people on the front lines who are dealing with monopoly power, competing with it, winning, losing, but ultimately winning.

David: It's a podcast about all the money and power in the world.

Theme: And we know now that government by organized money is just as dangerous as government by organized mob.

Matt: So welcome Tim. Tim is the president and the chief legal officer of Hercules Pharmaceuticals, which is a pharmaceutical company. Wholesale distributor, what does it actually, what does drug distribution company actually do?

Tim: Hello, Matt. Hello, David. We buy drugs from pharmaceutical manufacturers. We receive them into our distribution center.

And then we sell them nationally to a pharmacy, a hospital, or a doctor practice.

Matt: How do you make money? You just do like a markup on the drugs you're selling or what?

Tim: There's essentially two ways to three ways to make money in drug distribution. One is the difference between the price you buy it for and sell it for.

Another is a service fee for wholesale distributors. And if you own a group purchasing organization and are coordinating a group purchasing organization, you could get a service fee for that.

Matt: And where, where's your company based and how many employees do you have?

Tim: So our company is in Port Washington, New York, and we have over a hundred people employed in, in distribution.

David: What do you think you do that gives your company a leg up, you know, when, when a customer sees Hercules, why are they inclined to come to you?

Tim: We compete on value. Uh, some might call it pricing, but we compete on what we call value. So it'll be cheaper for a manufacturer to distribute through us.

It'll cost a hospital or a doctor's practice less money to buy from us. But we also add this thing called ethics and compliance. So we think that ethics,

Matt: Yeah, ethics, everybody laughs. That's it. That's adorable.

David: Yeah. I know. I know. Secret ingredient is ethics.

Tim: Yeah. Yeah. Yeah. Yeah. I didn't go to business school, so, uh, I'm still all shucks on, on, on ethics.

But if you look into the pharmaceutical supply chain, you have a massive proliferation of opioids and you have continual placement. Of, uh, adulterated drugs. Or counterfeit drugs. So I think it's a ripe, uh, ingredient that's missing from pharmaceutical wholesale distributors. Also, typically I find a lot of the participants in the pharmaceutical distribution channel, people who work for doctor practices, people who work for pharmacies as ethical people, and they really are not happy internally with the state of distribution in the pharmaceutical drug supply chain.

Matt: So I read your website and I saw in your marketing material, I mean, you actually write, and this is on your front page of your website, is a privately held and independent company without conflicts of interest. Hercules represents your competitive alternative to help you minimize risk and add value.

So it is actually true. You're basically marketing yourself as we're not pathological liars. Correct. Which I think is general, I mean, you know, opioids, adulterated medicine. It seems like you probably want to buy your medicine from someone that's not a pathological lab. I'm not in the industry, that's my guess.

But I wanted to ask you, drug distribution seems a bit like a commodity business. So you send trucks to go get drugs, you put them in warehouses, you make sure the temperature is managed properly, sanitation, medical standards are fine. You make sure you have enough inventory on hand. Is that right? You know, is that the basics of it? And then what is actually hard about the business?

Tim: So, so correct. It's essentially a pick, pack, and ship model that has or ought to have a, a, a significant compliance input so we can guarantee that somebody's family member, that the drug was in the correct ambient condition as it traveled through the pharmaceutical supply chain, we can, we can show that it got into the correct people's hands.

So it's pick, pack, and ship, uh, with a lot of compliance that should be auditable.

David: There are kind of specific things that you have to, uh, be aware of, uh, this isn't about putting nuts and bolts in a factory and just waiting until you have to get it out. There are very specific, you know, ways in which these drugs have to be held.

They have to have a certain temperature. They have to have a certain, certain set of standards. And, and, uh, the question is, is that kind of the major challenge for you?

Tim: It's actually not that hard. We're very proud of what we do, but it would be hyperbolic for me to hoist it above what doctors and nurses and pharmacists do every day.

Matt: So let's get to what is difficult, right? Which is the reason that we have this podcast and the reason we're talking to you and probably the reason there are shortages and the reason there's all lots of problems in the medical supply chain. If it's not that hard. Right. And by the way, I

admire the fact that you run a company and you're like, what we do is not that hard.

I respect that. Right. Cause it's honest. I'm so sick of the MBAs being like, we're really cultivating value at like they sell Cheetos or whatever it is.

David: Try to keep it real. What we're doing is we're innovating the entire idea of a snack food. Yeah. I love that.

Matt: I mean, I, I, the, the word ideation needs to come up, which I'm not a fan of the death penalty, but I am fan of death penalty for using that word.

Okay. Okay. So, so Who runs the drug distribution industry, right? You're a relatively small player. You know, there are the big three. Who are they and who runs it? Sure. So there's three

Tim: major wholesale distributors there, uh, Amerisource Bergen, which is now called Sancora, McKesson, and Cardinal Health. Our research shows them controlling 98 percent of the market.

David: Oh, wow. I mean, uh, is it the case that these three companies are competing with each other? Each other, or is it more a situation where they kind of divvy up various markets throughout the country?

Tim: What happens is any health care provider will get locked down with the prime prime vendor agreement. It's a simple contract, not a simple contract, but it's a contract.

And if you're a pharmacy, You need all different types of drugs, brand and generic, from all different types of manufacturers. And to get access to that brand medication, you need to sign what's called the Prime Vendor Agreement. And um, there are some kind of anti competitive metrics in that Prime Vendor Agreement.

David: So yeah, this is, this is something we've also heard a lot, like a lock in. So you're saying if, if they, if a pharmacy signs a contract with, let's just pick one McKesson, are you saying that they have to continue to buy those same drugs with McKesson over the course of the contract? How does that work?

Tim: So what will happen is You'll get your patent protected brand medicine patents like a monopoly.

You understand patents. They last slightly under two decades. So what happens is because McKesson or Cardinal or Amerisource Bergen typically have the exclusive national distribution rights to the patent protected med medicine, they're able to control the rest of the market.

Matt: It was so like patent protected would be like the new obesity drugs, right?

Yeah. Versus like very old drugs. Correct. So, so you're saying these, these guys have like exclusive distribution of like what Ozempic, right? So you can't distribute Ozempic or one of those drugs. Is that what you're saying?

Tim: There is true exclusive distribution, but brand companies align around these three major wholesale distributors, and it creates a phenomenon if you're a pharmacy and by volume, maybe 8 percent of what you dispense is brand, but by value, it's might be 85 or 90%.

And so what they do is they use that access to brand medicine and your acquisition cost. To tie in the generic volume, which is about 90 percent of, of your market.

Matt: So, so let me just say, so if you're a pharmacy, cause I talked to some pharmacists about this and, and what they tell me is, look, you know, I'm a McKesson pharmacist or I'm a Cardinal pharmacist.

I have to buy all my drugs from them because if I don't, then the prices go up and I go out of business. You can't pitch that pharmacy no matter how good your prices are because they have to buy 90 percent of their drugs from one of the big three.

Tim: Correct. It's also things like rights of first refusal.

So let's say we find a willing generic manufacturer and we cause them to work with us. We go, say, to a doctor's practice and say, here's the new value. Doctor's practices. We love your ethics. We want to change the world. My old price could have been lower, but they were overcharging us

by tens and tens, and sometimes hundreds of thousands of dollars a month for this drug, but guess what we're contractually obligated now to show your price to your competitor who has 98 percent of the market.

And when they match it to give them all the business in volume. So what happens is with the rights of first refusal, anytime there's a green shoot of competition in the marketplace. The rate of first refusal is the big boot of the oligarchy that steps down on it and crushes it and make sure, and make sure that any market competitive initiative is dead on arrival.

David: How is this manifesting in terms of what ordinary people, how, what they have to deal with? You hinted at one, that it makes drugs maybe more expensive. What are the other issues that come with setting up a market in this way? So

Tim: not only are drugs more expensive and put on higher and higher shelves, if you're a generic manufacturer, You are under the boot of these major three old oligarchs, uh, McKesson, Cardinal, and Emeritus Horst Bergen.

They force pricing below cost and they force their service fees into a below cost scenario, which has led to perhaps not the only input, but a significant input, which has led to generic manufacturers getting out of entire lines of important generic drugs. Uh, particularly. in the infusible generic chemotherapy space.

There's some critical generic drugs that are not expensive. But these generic manufacturers have been forced into such a state that they can't even afford to make lots of these drugs anymore.

Matt: So, so it's, it's interesting that you talk about how these companies raise prices to pharmacies, but then on the other hand, they lower prices to the manufacturers, but it's sort of like, The market signals of pricing are broken.

If it's a really cheap cancer drug, that's whatever 5 or something. I'm sure parents who kids who have cancer would pay anything for that drug. Certainly they would pay 10 or 20, but they can't because. These middlemen won't let that price rise to make it possible to even manufacture

it. Do I have that right in terms of kind of why there are shortages of these easily producible drugs that we've known how to produce and have produced for 20, years?

Tim: Absolutely. So let's pretend David's the generic manufacturer. I'm 3 more for this 15 drug. I then work with David and say, Hey, You're doing a lot, David. I'm going to compete for your business. We get together, then I go to Matt, who's a, uh, large scale oncology practice, and I say, Matt, I'm now paying David more to bring you, Matt, the drug for less.

Let's do it. Here's my ethics. Here's my compliance. We'll work together and through the market, we will fix this, but it doesn't happen because what they will do is they will come in and say, up, we're going to exercise our right of first refusal, kill the early sprouts of competition and what it could bring, or they're going to say, We're going to enforce our contractual rights against you because you are obligated to purchase 90 percent out from us.

This is what we face day in and day out.

David: Right, and that's where we get the shortages in, right? Because, uh, you're saying that it is no longer because of these middlemen, it is no longer affordable, there is no longer a revenue producing concern for these manufacturers to actually make these drugs.

Right. Because they're cheap, uh, even though they are vital. And so once you have Essentially sole source, uh, suppliers for these products, any disruption can create a shortage. And that's why, you know, we go on these websites at the FDA and see hundreds of drugs and shortage at any one time. Is that, that about right?

Tim: Yes. And a parallel plane is a generic manufacturer, just increasing. It's volume or market share so big because they're, they're the ones who could just do it the cheapest, but still the margins are so razor thin that they're holding on by a finger and they're not able to reinvest and scale up their internal compliance.

Okay. So then they're suffering that way and unbeknownst to the FDA who sends the inspectors in the FDA comes in and says, Oh my goodness. Your manufacturing is not up to par. It's not up to scale. And then they shut the

manufacturer down and removed 60 percent from the market. Sometimes, sometimes greater.

And so not only does the big three ability to force generic manufacturers below costs, have generic manufacturers leaving the market. In critical moments where they could stay in the market, they can't scale up their compliance program to match the, the, the market they're taking.

David: How did we get to this point? That, first of all, that doesn't sound terribly legal, number one. And number two, it doesn't seem like there's any, any reasonable oversight of this industry would say that's really bad practice and it's costing people, you know, the ability to access drugs and potentially their lives.

So how did we get to this point where you have these behemoths? This is the, um, what

Matt: the, what the bleep part of the show. We're like, wait, what? Right.

Tim: Yeah, well, WTF number 3422 in today's America, lots of horizontal consolidation, wholesalers, buying wholesalers, merging with wholesalers, eating wholesalers.

And then there's been lots of vertical consolidation. For example, there's this Apparatus Corporation called Pharmacy Service Administrative Organization, PSAO, they negotiate. So David's the pharmacy, PSAO negotiates with payers, OptumRx, Expressscritps, Caremark, others. So wholesale distributors who provide the acquisition cost to David are also now the PSAO negotiating what David will sell a price for.

So once you know what your customer is selling a product for, and you're able to tie critical elements like brands and generics, You're able to calibrate the price to the unbearable level. It's it's, I believe the Greek goddess Tantalus, you put the water right up to the nostrils and, and you ensure it.

And then there's another apparatus called group purchasing organizations. And you use that to extract more value out, both for manufacturers and just the system in general.

David: So you're saying it's a great market, it would save people's lives, that there weren't six layers of middlemen that were getting in the way.

Tim: It's a three card Monty game or a shell game. If you go in front of Port Authority bus station, there's some really talented street youth who could do a three card Monty game. If this is who should be hired because they would understand the con immediately.

David: These guys are just on the 32nd floor instead of out in front of Grand Central and they're in companies that are among the biggest companies in the world.

Tim: Correct.

Matt: I have two sort of responses to listening to this is it's like, okay, more and more like this is just a bunch of contracts that are crazy. First of all, I feel like we should have this conversation in Yiddish because I'm sure there are Yiddish expressions for all of this.

David: Yeah. Well, there's a lot of chutzpah going on.

Tim: Oh, just, just consider that from the 1980s to today, the cost of a financial transaction has relatively diminished thanks to technology, displacing workers.

Also since the 1970s or eighties, the price of moving a parcel of a good domestically, thanks to UPS and FedEx has also decreased relatively. It's a lot cheaper. Why has. Wholesale distribution, which essentially moves boxes in, in, in domestic commerce, and then has a, a sideline financial transaction. Why has that gone up by hundreds and hundreds and hundreds of percent?

David: Yeah, it doesn't make any sense. And you mentioned, you mentioned horizontal integration, companies buying companies. The reason Amerisource Virgin is such a mouthful is because there was, there were several companies in that, in that transaction at one point or another. That's why they had to change their name to make it.

Make it sound really, uh, forward thinking, I guess. But you also mentioned vertical integration, and that's what we're starting to see even, even in a more aggressive fashion. So, so earlier this year, a few months ago, McKesson agreed to buy Florida cancer specialists and research Institute, a couple months ago, Cardinal.

Bought integrated oncology network for a little over a billion dollars. So now not only do we have Uh, you know drug distributors buying drug distributors, but now they they appear to be buying providers I

Matt: want to just interrupt here because in the time that we prepare so we do these questions We prepare questions and stuff in the time that we prepared that question There were a few more acquisitions Right.

So it's not, it's like, it's like they're, they bought like a, like a, like a dialysis, like a retinal group, like a bunch of others.

Tim: Yeah. Gastroenterology. And then a direct to patient

David: diabetes pharmacy. I'm sorry. I'm not the news ticker, Matt. I, I, I missed a couple, but you get the basic point here. The basic point is that, that these

Matt: companies are going into the provider.

I just wanted to give an indication of the speed of the acquisitions and how, how like the integration is happening really quickly and is really weird. You don't, you don't have to be

David: sorry for correcting me. Um, uh, but here's the point. What is the impact of that? Because now we have companies that, that.

And by your, uh, description really are knuckling under these providers of drugs and now they own some of these providers of drugs. What could be the impact of that?

Tim: I would first start by saying, um, our independent physician groups are, are, are some of the best people out there, some of the best energies out there, and they're really a crown jewel.

Set of crown jewels for American healthcare. Um, I, I would then say that they've been kind of exploited, uh, by these prime vendor agreements. By these group purchasing organizations, which in my FTC comment, I point out they function as a, an engine of fiduciary fraud, which places them paradoxically outside the safe Harbor.

They're supposed to be in. Um, and then, you know, having pretty much these physician practices have pretty much been subject to this kind of want and exploitation. You know, they're now forced into considering selling out to these major entities. It's tough, it's complicated. Also complicated is that these major three wholesale distributors are admittedly recent opioid proliferators.

So, if pharmaceutical industry induced, Opioid epidemic costs 3. 5 trillion dollars, plus minus. We're going to go permit admitted opioid proliferators, two of which who were just found guilty by a Maryland jury just last week for proliferating opal opioids last week. We're going to go and let them purchase.

And control physician's practice. I know this is an antitrust show. And I, and all my friends who are deep and pickled in antitrust are always saying, Well that, that's not really part of the

Matt: antitrust equation, but This is when we need the Yiddish words. Cause we just can't express it. Right?

Tim: No, I feel like Mugatu and Zoolander were, were, were, were the crazy pills.

Matt: So these guys, like, let's say ethics are not their strong suit. It sounds like that's my takeaway here. But if they own a physician practice, like a cancer network or a cancer specialist, are they going to encourage people to take certain treatments maybe? And it's not the best for their condition or,

Tim: or is that the concern or what?

Again, I would say the vast preponderance of doctors are, are good people and even a greater percentage of nurses. Okay, but as we saw in the

proliferation of opioids, there were some doctors who made some egregious choices. When you look at which drugs a practice will prescribe, you know, that's kind of called their formulary.

And they will have a team of medical experts because two or three drugs might get at the same disease, might affect it, might mitigate it. And it's called the clinical committee. And typically, the clinical committee is happening up at the business organization leadership apex of that doctor's office.

Business practice. So, so if, if, if you're a, if you're an oncologist, you're seeing a patient, the patient is sick, you're not thinking clinical outcomes of what drug we're going to carry throughout all of our practices, you're just focusing on that patient and you're going according to the protocols of, of cancer doctors and also your practice, like what drug we're working with.

So the problem is that. It, the decisions are made concurrently up closer to that business leadership area where McKesson Cardinal and Amerisource are buying.

David: What you're saying is, let's say that that meeting is being held, this hypothetical meeting. Okay. What drug are we going to use for this, uh, you know, whatever our patients, if they have this particular condition.

And someone comes in, in a very nice suit and says, I have a thought. Let's use the drugs that we're the exclusive distributor of. And then let's say that something down the road happens in, you know, some, some trial or some estimate of things that are happening and there's a bad condition that comes out of that, that drug.

There's a lot of pressure from that guy in the suit to say, well, you know, that only happened to a hundred people that they, they suffered a horrible malady. Let's keep using that, that drug because it's really good for me. And that, that moment where that comes into the equation is the moment where ethics go out the window.

Tim: And I'd also add this, let's say Matt and you are generic competitors. And let's say Matt is a better and more ethical company that has a better compliance program. Okay. [00:30:00] But then all of a sudden David

comes in and says, Hey, look, I know you own the wholesale distributor. You are the wholesale distributor.

I know you own the group purchasing organization. I know you control these, this group of doctor's practices because it was an acquisition of yours. Well, you know what? Let me give you more service fees at the wholesale distribution level. Let me give you some more service fees feathered into group purchasing organization outside and above the safe Harbor.

And, and, and, and, and I'm going to go with this really big price. So those bigger service fees will be much bigger. Okay. And so the oncologist who is now forced to see 20 percent more. Patients or 10 percent more patients. And because of the acquisition, they're not thinking that they're thinking, I have all of these patients here.

I want to do correct and right by each and every one of them. They're thinking of the cost of, of them being there. They have their mortgages, their homes, their families. And so the last thing on the mind. Is the backroom and the backroom deal

David: right and they're thinking I'm in this to help people I can help people within these parameters and so if I have to, you know, make this this decision based on some sort of bottom line that's being told to me from my superior, I'll do it and then and that just sort of chips away.

There's a term that doctors use called moral injury. And, uh, that's where the moral injury comes in when all of a sudden it's, it's about the profits, it's not about the patients and, and you rationalize that.

Tim: Absolutely. And it's, you have, you have our system of healthcare begins with our manufacturers and ends with our payers.

And so what, what competition does is it will create a, a better allocation of value through there. Okay. Now, if evil David manufacturer got together with greedy wholesale distributor, Okay, that stuff happens, but I should be able to come in and compete with that. I should be able to say, here's an alternative.

And that's the way markets can put ethics in place. That's the way markets can manifest public policy and health policy.

David: I just want to say in your scenario, I've been evil. Dave like six times and I'm, I'm a nice guy. I just want to, I just want to make that very clear. Go ahead. Are you done? Cause I'm afraid of you.

Matt: Okay. So you're going to let me, I was afraid of evil.

David: I was upset. I'm sorry. I apologize.

Matt: It seems like there's a lot here that feels icky. It doesn't feel like what you're describing is, shall we say, street legal. What should the government or anyone else be kind of doing about this broad problem of consolidated drug distribution and shortages?

Tim:I think that the government and regulator needs the kind of quote unquote come to Jesus moment. It happened in the 70s and 80s with the banking industry and money laundering. The then culture of banks and financial institutions. Facilitated significant societal harms and undermined important policy goals.

So we need that. We need that moment.Certain industries need to be regulated. Airlines for safety. I'm a libertarian up until I walk on a, a, a passenger jet.

And then I'm quite hap Sure. But I'm quite ha I'm quite happy with regulators, okay? They need to understand that the pharmaceutical supply chain, we don't have a regulator, really. We have technical regulations, but no one's often knocking on, on doors, there's a patchwork of, of state and federal regulation and that a, a decades old law, which is still yet to go fully into effect, it's called the Drug Supply Chain Security Act, took power out of the hands of the states to regulate the pharmaceutical supply chain.

It deputized the FDA and then it outsourced the deputized power to the private industry. So, so kind of like banks begrudgingly don't like Federal Financial Examination Council or Office of the controller of currency. Um, we need, we, the, the pharmaceutical supply chain needs regulators not to, like,

Tim: And I always try to do a back of the envelope on what's the anti competitive margins here?

You know, if you look at wholesale acquisition costs of brand medicines, right? So I believe brand medicines is about, I don't know, 520 billion, let's pretend. Um, uh, so is it 2 percent that, that we're overpaying this as a system because we don't have a number of wholesale, uh, distributors competing to drive value and brand, and then what about generics?

It could be a 60, 70, 80 billion. Dollars. What is being stolen from the manufacturers? 10%? 12%? And then what is being overcharged to, to healthcare providers? 20%? So this is real numbers. I mean, in a decade, we could get up to a quarter trillion dollars, which is maybe even slightly big money for Washington, DC.

So I think that competition can drive value. And as we look at the proliferation of the cost of debt, if we look at, uh, the cost of our military, okay, there's going to be greater and greater, uh, powers competing for that diminishing federal dollar and competition and health care can really be one of the ingredients that helps fix some things

David: Well, that's great. We're definitely going to want to check in uh in the years ahead tim ward is the president and chief legal officer of hercules pharmaceuticals Thank you so much for being here on Organized Money.

Tim: Thank you for having me.

David: Well, we'll certainly keep an eye on that, and we will be back next week with more stories of Monopoly on Organized Money. Organized Money is a production of Rock Creek Sound, executive producers Ellen Weiss and Ari Saperstein. Our senior producer is Benjamin Frisch, who also does our sound design, all the mixing, and our artwork.

If you love this topic as much as we

Matt: do and want to learn more, You can follow my sub stack newsletter, Big, at thebignewsletter. com, and follow me on Twitter at Matthew Stoller.

David: And you could definitely check out my magazine, The American Prospect. That's at prospect. org. And I'm on Twitter at ddayen. D D A Y E N.

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