

## 'It All Comes Back to China'



By *Chuck Dinerstein, MD, MBA* — April 2, 2020

*Those are the words of New York Gov. Andrew Cuomo, describing the "twist of fate" that finds us awaiting personal protective equipment, ventilators and pharmaceuticals manufactured -- yes -- in China.*



Courtesy of Sandstein on Wikimedia [1]

In the next few weeks, we will experience the downside risks of offshoring. Moving manufacturing to areas with specialized expertise should reduce costs and provide a better product. It also serves to bind us together economically and socially; you are not so quick to disrupt relationships – not quite a tit-for-tat, quid pro quo, but in that ballpark.

Offshoring, as with many decisions, involves a tradeoff, lower costs, better quality to us, jobs, and income to them. Everyone loves to pay less; consumers certainly do, companies do, for both groups, it improves their bottom line. A small set of consumers, those whose jobs are displaced, are not as happy. But as long as they could be retrained, or were invisible because of their numbers or power, they didn't figure into the calculus. Before responding that this is the fault of Big whoever, we should recognize that all of us, buyers or sellers, have a role in this decision.

The combination of loose oversight and large production allows for unethical behavior by bad actors, to thrive for longer periods of time undetected. In 2007, we received pet food contaminated with melamine; in the past six months, both valsartan, a medication to control blood pressure, and now ranitidine, you may know it as Zantac, have been recalled because of contamination with carcinogens. Chinese companies delivered "faulty" COVID-19 test kits to the EU in the last few weeks.

A recent study, by the Center for Infectious Disease Research and Policy (CIDRAP) at the University of Minnesota, looked at our pharmaceutical supply chain and reports:

- *156 critical drugs have been identified that are needed for acute care within a few hours to days or patient mortality rises;*
- *many of these drugs are made, formulated, packaged, or have an API [active pharmaceutical ingredient] made in China, India, Italy or other severely affected countries;*
- *the precise health risk of drug shortage to the US healthcare system is difficult to determine due to the lack of structural transparency and available supply chain data about drugs, which may be known by pharmaceutical companies, wholesalers, suppliers, and contract manufacturers, but not shared with the Food and Drug Administration or the public.*

80% of the medications marketed in the US are manufactured offshore, 66% of those APIs come from China, and are then, often shipped to India, for final manufacture. Because of recalls and issues of quality, many drugs that we commonly use in hospitals have been in short supply for years. CIDRAP [identified](#) <sup>[2]</sup> 156 medications "used in acute care that, if unavailable for a few hours or days, can lead to increased patient death rates." Sixty have been unavailable off and on for years. More to the point

*"What we are seeing now is some products that are in a shortage and others that are in a very tight market," he said. There was a 51 percent increase in demand for sedatives and anaesthetics in March, compared to the same period in January, before the coronavirus pandemic hit the US. Now, only 63 percent of these orders have been fulfilled. For analgesics, a kind of painkiller, demand rose by 67 percent. Orders for neuromuscular blockers, which relax muscles, rose 39 percent.*

[Dan Kistner](#) <sup>[3]</sup>, group senior vice-president, pharmacy solutions at Vizient <sup>[1]</sup>

And please understand, sedatives and neuromuscular blockers are part and parcel of caring for COVID-19 patients requiring ventilators. Those shortages will impact how many people can be placed and comfortably maintained on these life-supporting machines.

Some of these shortages are due to manufacturing issues and others due to what is called a just-in-time inventory system, which keeps "on-hand" supplies low to reduce storage costs. Still, it counts on a reliable, continuous source of the product to replenish supplies. Just-in-time inventories don't do surges in demand well. And that reliability is further compromised when the lives of the manufacturers are at stake. Once President Trump suggested that hydroxychloroquine might be a useful medication in the fight against COVID-19, India banned its export. As the NY Times reports, that ban extended to PPE, ventilators, sanitizers, and acetaminophen, Tylenol. Trade is good, but in a life or death situation, the human-animal and its governments protect their own.

***"We want companies to make their products here, and source them here, but they won't do that unless they make a profit," said a senior Republican aide. "And we want them to make a profit. The biggest question that we have been grappling with is: how can we incentivise them?"***

In a market economy, the main incentive is the Benjamins. Tariffs and tax-breaks are the usual regulatory responses. Currently, there is an appeal to patriotism, the same appeal that caused us and many other countries to halt exports of strategic goods. Patriotism is too ethereal to last as a long-term incentive, and these companies are global company-states, in the mold of British East Indies Company.

One of the best ways to level the marketplace is transparency and reputation. You stop buying from cheats and price-gougers because other alternatives are clearly seen. The first step in the process is to identify every step in the supply chain for pharmaceuticals, from raw ingredients to APIs, to the final manufacturer. Whole Foods can do this with their fish and meats; certainly, we should be able to do this with our medications. As it turns out, companies are not sharing this information with researchers or the federal government.

*"David J. Margraf, PharmD, MS, a research project specialist with the CIDRAP team, said pharmaceutical companies are required to report some supply-chain information to the FDA, but the data can be up to 6 months old and tends to be very vague. The companies "don't give a clear reason as to why there might be a shortage." Osterholm said the researchers have directly asked the drug companies for details on their supply chains, but "none of them have been willing to share information. And for that matter, the US government doesn't have it either."*

The CIDRAP analysis made use of data from New Zealand, where "[t]hey require approved marketers of products to disclose the supply chain—where was the active ingredient made, where was it packaged."

With that type of data, we could identify the bad actors and remove them from our supply chain. That data would allow us more strategic insight into where dependencies are most significant and create a backup plan. It could be alternate manufacturers or better still bring that work home; providing sustainable jobs for our workers, and income that when spent locally, can restore our

shattered and hollowed-out communities. It may cost us a bit more, but now that COVID-19 is beginning to reveal the real cost of those decisions, in terms of not being able to care for our nation in its time of need, shouldn't we insist that our companies rethink the tradeoffs they have made. If you want to sell pharmaceuticals in the US, you must be able to publically identify, for every lot of pills, every step in the supply chain. It is called whole-chain traceability, and if we can do it for a cow, we can do it for a medication.

[1] Vizient is involved in hospital operational management including their supply chains for roughly a quarter of US acute bed hospitals.

Sources: [US lawmakers push to reclaim medical supply chains from China](#) [4] Financial Times

[Experts say COVID-19 will likely lead to US drug shortages](#) [5] CIDRAP Univ. of Minnesota

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[5] <http://www.cidrap.umn.edu/news-perspective/2020/03/experts-say-covid-19-will-likely-lead-us-drug-shortages>