HEALTH CHOICES AND RESPONSIBILITIES

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Dedication

This book is for the important women in my life:

Ella, my wife who helped edit some papers here and watched the kids as I spent several long nights polishing this book

Elle Marie and Bien Mary,
our young and lovely daughters

Nenita, my mother in law

Consuelo, my mother

Marycris, my sister, who provided me with various logistical support in my work at MG Thinkers.

And

Cristela, one of our dear wedding godmothers, who bravely fought a severe and rare cancer. Our Creator has already taken her and gave her eternal peace.

Acknowledgment

Aside from the people I have mentioned in the Dedication, I would also like to thank the following for their various support:

Bon Fernandez, for his artistic designs of the front and back cover of this book.

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Web Philippines, Inc. for hosting and administering the MG website for free.

Fellow free market thinkers and leaders in Asia and other parts of the world. People who advance the principles of individual freedom and more personal responsibility to create a peaceful and honest society in the future.

Introduction

Finally, I am publishing my first book! I have been blogging for more than five years now at http://funwithgovernment.blogspot.com, The thought of someday publishing my own book has been there since about two or three years ago.

Since last year, I gave more public lectures, wrote more op-ed articles, and posted more frequently in my blog on many topics – health and medicines, climate, taxes and public debt, trade, politics and political theory, humor, and so on. The "itch" to produce a book was more intense recently. And here it is!

I chose the topic on health for my first book for three important reasons. **One**, healthcare is a very important topic both for my policy studies and for personal reasons. Any of my two daughters will get sick, or my wife or my old and weak mother will get sick, I immediately get distracted from work and writing.

Two, I have a number of first-hand information on some public health issues in the country as I am a member of the DOH Advisory Council on Price Regulation, recently converted to DOH Advisory Council on Healthcare. I also represent and head our free market think tank, Minimal Government Thinkers (www.minimalgovernment.net) in an alliance of mostly health and research NGOs called the Coalition for Health Advocacy and Transparency (CHAT). CHAT is the civil society partner of the Medicines Transparency Alliance (MeTA) Philippines chapter. So I have attended a number of public forum, lectures and meetings by CHAT, MeTA Philippines and the DOH Advisory Council over the past two years.

Three, I have written a lot about this sector in the past few years, from intellectual property rights (IPR) to health

insurance to drug price control and so on. It is time to collate the various papers I have written on the subject into a book.

All the short papers and op-ed articles here are posted in my blog, including those that I have written for other media outlets like www.thelobbyist.biz, the weekend tabloid http://www.peoplesbrigadanews.com/wpress/index.php, and guest op-eds in other national and international newspapers. Those papers that I wrote just for my blog have been slightly revised and edited here to correct some grammatical and related errors.

Finally, I chose the title ***Health Choices and Responsibilities*** because of my two firm beliefs: **One**, people have control and choices in taking care of their body and mind, that there are plenty of individual choices to be healthy or be sickly, and there are many choices in financing healthcare. And **two,** healthcare is mainly a personal and parental responsibility, although a few health issues should fall under government responsibility.

I hope that readers will find the ideas and data presented in this book worth pondering, even if they are mostly "politically incorrect" and contrary to mainstream perspectives on health.

Cheers!

Bienvenido "Nonoy" Oplas, Jr.

January 11, 2011 (1-11-11)

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1. DOH Advisory Council on Price Regulation, meetings in June 2009

(This is a merged and slightly expanded paper of my two blog notes “DOH meeting on price regulation, part 1” and “DOH meeting on price regulation, part 2”)

21 June 2009

The Department of Health (DOH), as mandated by the Cheaper Medicines Law (RA 9502), is to form an “Advisory Council on Price Regulation”. The Council was formed early this year and so far they have conducted 5 meetings. I have attended the last two meetings – the 4th meeting last June 5 and the 5th meeting last June 19. I have not attended the first three council meetings, two of which were scheduled on days that I was out of the country.

June 6 was the 1st year anniversary of RA 9502. June 8 there was another meeting by the Senate Oversight Committee on the law and the Committee is headed by Sen. Mar Roxas.

The Advisory Council has a good mixture of participants. I categorize them into 5 groups here:

(1) Federation of pharma companies, the Pharmaceutical and Healthcare Association of the Philippines (PHAP) and the Philippine Chamber of Pharmaceutical Industry (PCPI). The former is composed mostly of multinational pharma manufacturing and trading companies, while the latter is composed of Filipino companies.

(2) Drug retailers, particularly Mercury Drugstore, the Drug Store Association of the Philippines (DSAP), The Generics Pharmacy, and Watsons.

(3) Civil society groups, particularly the Cut the Cost, Cut the Pain Network (3CPNet) - Medical Action Group (MAG), Cancer Warriors Foundation (CWF), Ayos na Gamot sa Abot kayang Presyo (AGAP), and Minimal Government Thinkers. I represent the last group.

(4) Multilateral institutions like the European Council (EC), World Health Organization (WHO), GTZ (German foreign aid), etc. Although I think not all of them attend the meetings every time, only on issues where they have some involvement or projects. The UPSE Health Policy Development Project (HPDP), funded by USAID I think, also attends the meeting.

(5) DOH and other government agencies like the Department of Trade and Industry (DTI), Bureau of Food and Drugs (BFAD), and the Philippine International Trading Corporation (PITC).

The 4th meeting last June 5 was held at the WHO Western Pacific Regional Office (WPRO). The main agenda then were (a) WHO's national essential medicines facility (NEMF), (b) list of medicines for possible issuance of maximum retail price (MRP), and (3) a draft proposal by DOH to regulate discount cards by pharma companies.

The goal of NEMF is to "harmonize and ensure uniform standards of procurement across the public sector, ensure selection of reliable suppliers of quality products" The essential medicines targeted are for (a) TB, HIV and malaria, (b) vaccines, (c) emergency obstetric care, (d) chronic diseases, (e) neglected diseases, and (f) PhP program and "botika ng barangay" (village pharmacy).

The discussion on list of medicines for issuance of maximum retail price (MRP) or price control was long. DOH UnderSecretary Alex Padilla, USec for Health Regulations and convenor of the Council, narrated how difficult it is to

face legislators who want price control, just to show to the public that the government is indeed "serious" in enforcing the cheaper medicines law. The DOH understands that it's not easy to issue price control and fully implement it, but they are sometimes castigated in media by the legislators as "in cahoots with multinational pharma."

One will understand if PHAP will oppose drug price control because it is the patented and branded drugs by multinational pharma companies that are most likely to be targeted. One may even assume that PCPI will not object to price control because the products of their members are non-patented and generics. But PCPI leaders were very vocal in opposing drug price control.

This is because price control is essentially penalizing success. Any drug that has become popular and highly saleable, whether patented or not, can be a target for price control. Many PCPI members are now good manufacturers, they are capable of producing popular medicines. That ugly state intervention in pricing called MRP will soon hit them.

I spoke, of course, on this subject at the meeting. I noted that price control is a favorite advocacy of socialists under economic central planning regime. It is driven by plain envy with "suffering of the masses" as smoke screen.

Suffice it to say that with the exception of two voices in the meeting, almost everyone, including drug retailers, agreed that imposing price control at this time is ill-advised. It’s a proposal that was not supported by the majority of the Council members.

The subject of DOH regulation of discount cards by some multinational pharma companies was tackled next. It was the first time I heard that it is an issue. The DOH wanted to produce a draft Administrative Order proposing that whatever is the current discount price by those pharma

companies (usually 50 percent off their regular price) should become the “universal price” and must apply to all customers and patients, with or without any discount card.

There were two major arguments I could remember, that were raised in favor of this move. First, discount cards favor the rich, they are the ones who can afford to see a doctor regularly and doctors give out discount cards. And since discounts represent some revenue losses to the manufacturers, such loss has to be recouped from the regular customers, the non-card holders, who are the poor. Second, discount cards allow the pharma companies to have access to some health record of the patients, and there is ethical violation there.

I spoke twice on this subject. First, discount cards I think are marketing tools by suppliers and manufacturers; it is a unilateral, voluntary act on their part, hoping to increase their revenues and profit either in the short- or long-term. Such voluntary acts therefore, should be encouraged, not penalized. When discount cards are to be banned and whatever discount price was to be made mandatory, a cousin of price control in effect, I think this is penalizing those who initiated the discount. Such mandatory pricing would be more palatable if government will also offer mandatory reduction in business regulations and taxes for the affected suppliers. Since this is not forthcoming, then the move is pure penalty, not reward for a good job done.

Second, giving out information about the patient’s health record is no different from filling up an application form to apply for a credit card or open a bank account, where the applicant is giving away his/her personal information like monthly salary, if the house is owned or rented, how many cars owned, etc.

The replies to my points were as follows. On the first, it is not easy to expect the government to cut business regulations,

much less cut taxes, for suppliers who are offering unilateral discount promotions. On the second, information via credit card application is way below personal health information, they are not comparable. Health is on the top, above almost everything else. Hence, personal health information should not be accessed by just anyone, much less pharmaceutical manufacturers.

Anyway, we were asked to submit our formal position papers on this subject as the Office of the President was also waiting for the proposals of the DOH as collated from its various consultations.

It was a productive and very informative meeting, and I thanked the DOH officials and staff who were there for conducting such meeting and inviting a diverse group of participants.

The 5th Advisory Council meeting

The meeting was held last Friday, June 19, at the DOH. There were 3 topics discussed. First, an update on drugs that were recommended for MRP issuance by the President. Second, the proposed administrative order by the DOH on how to implement the MRP once the draft Executive Order (EO) is signed by the President. And third, the electronic data base on comparable drug prices, under the DOH website.

The DOH Secretary submitted the draft EO to the President only last Tuesday, June 16. The first official announcement of list of drugs under MRP was last June 8, during the Congressional Oversight Committee hearing at the Senate, where Sen. Mar Roxas, an LP Presidential candidate, most likely pressured the DOH to produce a list of drugs for MRP. The timing was suspect because it was one year since the enactment of RA 9502, June 6, 2008, and there was no clear national health emergency.

Were there new list of drugs for MRP? Maybe, no one knows yet except the DOH and the Office of the President. Between the announcements at the Congressional Oversight Committee meeting last June 8 to June 16, there could have been new drugs or those in the mentioned list may have been removed. The DOH said from 100 molecules, they later pared the list down to 25 molecules. The final list is with the President, and she will also make her own consultations before signing the draft EO.

Many of us who attended the meeting last Friday were also surprised that the MRP was pushed through considering that the majority sentiment during the 4th Council meeting last June 5, was that MRP is not necessary now, it should have not been pushed. PCPI reiterated their position that they are not in favor of issuing MRP now. I also spoke and argued that price-setting is not a function of the government. Since we advocate minimal government, there is no way that we can support State intervention in setting prices, in price control.

After another long and extended discussion on the inappropriateness of medicine MRP, the topic shifted to BFAD's Administrative Order (AO) on how the draft EO will be implemented. About 3 pages long, saying that drug manufacturers, distributors, retailers, etc. should put the label "price not to exceed the MRP of ____".

This proposal was shot down, not only by the pharma companies (multinationals and domestic) but also by leaders of drug stores. The main argument is that if there are signs that the prices of drugs that have been identified for MRP are coming down to 50 percent or lower, then no labeling will be necessary. Voluntary compliance should be encouraged. Since there are around 5,000 to 7,000 drugstores nationwide, the labeling will have to be done there – drugstore by drugstore, pack by pack, capsule by capsule, etc. This will

present a new logistical nightmare. There was a proposal to have a "transition period" of 3 months between the issuance of the EO and the actual implementation of price labeling. Some civil society groups objected, but they were later convinced of the complexity of hurrying the labeling.

I also suggested that since the government has intervened a lot already in drug pricing, government should show some sacrifice. For instance, should price labeling be necessary for some drugs, it should be the government that should do it, not the drug suppliers who already suffered huge revenue cuts, if not suffer losses, with the mandatory and forcible price control. Many participants from the government agencies howled in disapproval of my proposal.

The 3rd and last agenda was the electronic database for comparable drug prices. Although there are some noble goals for coming up with this list, aside from being mandated or suggested by the new law and its implementing rules and regulations (IRR), the list is projected to raise more high expectations from the public which will only result in high disappointment. For instance, some drugstores will cite prices for the e-database that are lower than their actual retail price and produce various reasons why they did so.

One vocal participant in the meeting commented on the side that we need minimal government on issues like drug pricing. Thumbs up to him, actually, a former friend way back from our undergraduate days at the University of the Philippines (UP) in Diliman campus.

Earlier, there was a discussion how to expand the number of participants in the Advisory Council meetings since certain important players were left out. For instance, people have assumed that all multinational pharma companies are members of PHAP and so, PHAP officials can articulate their sentiments. Turns out that there are 3 multinational pharma companies that are not members of PHAP – Pfizer, Servier,

and Merck. So these companies are expected to be invited in the next Council meeting next month, before the State Of the Nation Address (SONA) of the President.

The quality of discussions and debates in the Council meetings is high and very transparent. People who have “great” ideas on something can expect that it can be shot down if such grand ideas are not backed up by robust philosophies and solid data. Unlike in Congressional hearings where the presence of legislators is very imposing and dominating, the discussions in the Advisory Council meetings are more free-wheeling, fast and frank.

Meanwhile, below is the paper that I sent to the DOH after the June 5, 2009 meeting.

Position paper on the implementation of Maximum Retail Price (MRP) provision of RA 9502

June 6, 2009

Although the maximum retail price (MRP) or price control provision was incorporated in the Cheaper Medicines Law or RA 9502, it should be used only as a last resort. This is because price control is a draconian measure that can discourage the entry of more players that can otherwise add to more competition, and/or result in exit of some of players in the economy, which will ultimately lead to a monopolistic or oligopolistic industry structure, which is contrary to public interest.

There have been indicators that medicine prices are coming down – PCPI, PHAP and some drug store associations' figures would show – and this is already one proof that other provisions of RA 9502 were successful. We just have to encourage the entry of more players, especially among generics manufacturers, distributors and drugstores, to mature. Thus, draconian measures like MRP should be used only as a last resort, not to be implemented without apparent national health emergencies.

The eyes of the public are on the few multinational pharmaceutical companies in the country. Many or all of these are suspected by the public of "price gouging" and "ultra-high profit" through transfer pricing and high patented medicine prices.

But there are so many innovator pharmaceutical companies in the world that are not in the Philippines yet. And even plentier are good generics manufacturers from other countries. Even if just 10 percent of those big innovator and generics companies abroad that are not yet here would come, that will greatly expand competition and the public.

Filipino patients especially, will benefit with wider choices of more effective and safe medicines at competitive prices.

In a sense, it can be said that high medicine price is a function of or determined by – aside from high and multiple taxes on medicines – lack of competition. Although, there may be 2 or 3 dozen innovator companies in the country, not all of them compete on each and every medicine products for all types of diseases. It is possible that for a particular disease, there are is only 1 or 2 or 3 medicine manufacturers and sellers.

This is like there are several dozen bus companies in the Philippines. True, but they do not compete with each other in all or most routes. The bus companies plying the north-west Luzon provinces do not compete with bus companies in north-east Luzon, with bus companies in southern Luzon, in the island-provinces of southern Luzon, in the Visayas, in Mindanao.

In the initial list of drugs made by the DOH that are "candidates" for MRP issuance, a number of those medicine products indeed have only 2 to 4 suppliers, both innovator and generics. This is a thin field for competition. If the government will impose an MRP on the price of the most popular medicines, then the manufacturer or distributor of that medicine may pull out because it will be losing money. That leaves with only 1 to 3 suppliers, making the field of competition even thinner. And, the options for the patients become narrower.

There are various reasons for the non-entry of other multinational and innovator pharma companies into the Philippines in the past. Current policies therefore, should not add to such undesirable factors that can discourage or scare them further from entering the Philippine market and its 92 million citizens, growing at 1.8 million people per year, net of death and migration. The MRP or price control provision

without apparent national health emergencies can be subject to abuse. Politicians, health regulators, media and the public, can clamor for price control of any popular and effective medicines if they wish to, and the manufacturers and distributors of such medicines will suffer revenue cuts if not losses. This should be one of the factors that can scare those foreign pharma companies from entering the Philippine market.

The list of potential innovator players that can come into the Philippines is indeed very big. Even if just 10 percent of the above list would enter the Philippines, that would mean 15 additional innovator pharma companies here, with their wide range of effective and safe medicines, giving additional choices for Philippine-based patients.

The level of competition among innovator companies in the Philippines, even among multinationals, is very limited. There is a big challenge, therefore, for the Philippines to provide a welcome mat for many of those companies, innovator or generics, from anywhere in the world to come here, to further expand competition and choice for the public. Some Philippine-based pharma companies, innovator or generics, multinational or domestic, may find this a “bad news”. But this is not entirely so. Wider playing field means that the government’s interventionist and bureaucratic hands are staying away, allowing companies to focus more on improving their products and services for their customers, and they spend less time on complying with old and new regulations, they spend less on taxes and fees.

It is a win-win situation for all – pharma companies, drug stores, patients and the government. Pharma companies will have more leeway for innovation and services improvement. Drug stores will have more drugs to choose and sell. Patients will have more choices among so many suppliers of effective and safe medicines. And government will have more time to focus on its core functions like maintaining

peace and order, justice administration, less resources and bureaucracies to be spent on medicine procurement and health regulations and monitoring.

When there is a wide field of competition among pharma manufacturers and distributors, foreign patients abroad will notice this. Thousands of them, as well as Filipinos based abroad, who are seeking quick and quality health care will come to the Philippines because they know that there is a wide range of safe medicines available here from so many innovator companies from around the world.

This will help the local "medical tourism" industry, many private hospitals will also be putted up, which will create thousands of jobs for Filipino nurses, physicians, pharmacologists, and other health professionals. Many of these Filipino professionals then need not work abroad as foreigner and "kababayan" patients are coming here by the thousands.

If we have to extend the discussion, in the absence of any clear and compelling national health emergencies, government should keep at bay the provisions not only on MRP, but also of compulsory licensing (CL).

The main goal of RA 9502 is to bring down the price of safe and effective medicines. If this can be achieved by greater competition among players – and there are good indicators that competition is kicking in slowly that result in lower prices of a number of medicines – then the above-mentioned provisions like MRP and CL should indeed be kept as last resort measures.

2. Drug price cut without government price control

29 June 2009

I read the news report in the Inquirer today. Sanofi Aventis is cutting the price of its anti-diabetes medicine for patients affiliated with ISDF, a health NGO. I think this is a welcome move, a unilateral action on the part of a pharma company to bring down the price of its anti-diabetes medicines for selected, target patients.

My brother who died of prostate cancer a few years ago, was also diabetic. It was a deadly combination, diabetes + prostate C. He was lucky to have a private HMO plus my well-off sister's support who practically picked up most of the tab in his 2-years of messy and expensive treatment including chemo. The government? It was collecting taxes left and right for all the medicines that my dying brother was taking.

In the past 2 meetings of the DOH Advisory Council on price regulation that I have attended, there was a general feeling that whatever price reduction that a pharma company can give to certain patients, should be made as mandatory and "universal price" for all other patients.

I am not exactly in favor of such proposal because the pharma companies, domestic or multinational that extend such kind of price cut to certain groups or patients, have educational programs for their patients. They know who are the people buying their medicines, especially the poor patients, so the pharma companies that initiated the price cut can also give additional medical advice, like how to avoid diabetes in the first place. If such initiative is ok, Sanofi will make it a nationwide program, meaning nationwide price cut of their anti-diabetes medicine. Maybe through the patients' pysicians, if no NGO support groups like ISDF are not around.

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http://newsinfo.inquirer.net/inquirerheadlines/metro/view/20090629-212891/Price-of-antidiabetes-medicine-cut

Price of antidiabetes medicine cut

By DJ Yap
Philippine Daily Inquirer, 06/29/2009

MANILA, Philippines—Combating diabetes among indigent Filipinos has taken a step for the better—and the cheaper—thanks to a new partnership between the pharmaceutical company Sanofi-Aventis and the Institute for Studies on Diabetes Foundation Inc. (ISDF).

The two institutions launched on June 23 a new program called "Innovation for Life," a new, equitable, tiered-pricing approach toward increased access to insulin glargine (Lantus)—Sanofi-Aventis' diabetes medicine—among patients who could otherwise not afford it.

Dr. Ricardo Fernando, the founder of ISDF, said the project, which is seen to benefit more than 500 ISDF patients at the outset, was developed "not only for the next few months but for the long term…. We have to remember that the most expensive medicine is the one that does not work"….

3. Drug discount cards on facebook debate

19 July 2009

Yesterday, after reading some Manila newpaper columnists' articles on drug discount cards, I posted a status in my facebook account. Shortly after, several friends commented. Below are the actual comments. I thank them -- Elizabeth Cueva, a friend from UP and now a practicing lawyer in NYC; Eric Tolentino also from UP, and Gene Peters, for giving me permission to post here their comments.

Below are the exchanges:

Nonoy Oplas (is) Reading a number of news articles and opinions on drug discount cards. I only realized recently this is a big issue here in Manila. A marketing promo is now being pushed to be a mandatory promo; if you don't do it, you're an evil. hmmmm...

hi nonoy. isn't this really a way to track the doctor who prescribes the company's medicines instead of really giving discounts. great way to go around the senior citizen's benefit too! - Gil

Hi Gil. Yes -- track the doctors, the med reps, the patients, the drug stores, everyone who willingly agrees to the scheme, in exchange for lower price and continued patronage of a particular drug. If those pharma companies will distribute their discount cards to all doctors nationwide, let them continue their marketing promo, the State should get out of such promo. The State can invite more pharma companies to come in, launch their own promos, overall the patients will benefit. -- Nonoy

Yeah, the State should get out of the drug discount promo deal. It defeats the purpose as a marketing tool. The market

should drive it. People in the Philippines are actually luckier when it comes to access to vital life-saving medications. The state of the current U.S. health care system sucks big time. -- Elizabeth

Ah, many Filipinos do not realize that, thanks Elizabeth. Instead of recognizing the presence and merit of the few multinational pharma companies in the Philippines -- there are soooo many other multinational pharma companies that are not yet here that could help increase competition -- those few are being demonized. Even their promos, a unilateral and voluntary act on their part, is being seen as an evil scheme. -- Nonoy

I should know. My grandma and my mom are both pharmacists/ med techs there and their family used to own boticas in the Sampaloc, Manila area. The prices were lower with these "mom and pop" boticas which were wiped out by big drug conglomerates Mercury, Commodore. Still, the prices are more affordable than in the U.S. and generic medication more accessible. Thanks to Flavier for pushing the generic brands.

Here in the U.S. when I lost a job, I lost employer-subsidized medical and drug insurance coverage. I now have to shell out money for COBRA medical/drug insurance coverage and IT HURTS. The coverage is not even enough and I have to shell out more every visit to the doctor for treatment or prescription. So, for me prevention is really key. It is really fatal to get even slightly sick here in the U.S. without medical or drug insurance coverage because of the prohibitive price of medical care, treatment and medicines. -- Elizabeth

Commodore drug, *wala na yata dito*. Mercury and Watsons are the biggest drugstores now. The mom-and-pop type of boticas are partly being wiped out by government regulations. They make only about 5 to 15% profit margin because of

competition, but the senior citizens discount is 20% mandatory. Such loss is not even tax deductible. -- Nonoy

I read somewhere that in countries like India, exactly similar drugs (hypertension) can be purchased for just 1/5 the cost here. How true? And how can I get my hands on those drugs? Gimme, gimme... -- Eric Tolentino

Hi Eric, PITC, a government corporation, made that study, no one bothered to double-check the figures and computations. Even if the numbers are correct (ie, only 1/5 of price in India), those are prices there, not here. When those cheap medicines are imported into the Philippines, there are several costs to include: transport and storage, taxes (import tax, import processing fee, import doc stamp tax, local tax, VAT, etc.). When sold in drugstores, they are expensive again.

Also, note that it's under a parallel importation scheme. The foreign manufacturer abroad (say GSK or Pfizer or Roche, etc.) is different from the foreign wholesaler or aggregator, is different from the Philippine importer and distributor. If the imported drugs turn out to be fake or substandard causing allergies or death to patients, difficult to pinpoint who's to blame. -- Nonoy

Health care problems since then is a big issue in Manila, with a growing populace and deteriorating quality of living Manilans are more susceptible in many forms of ailment.. the real problem here is our policy on health care are lame and useless that’s why they put another issue on top of one that will never solve the basic problem of health care for all, benefits for some sectors are mere band aid solutions..while pharma companies rakes in the profits.. of course with the help of our caring doctors. -- Gene Peters

Hi Gene, in the first place, health care is personal and parental responsibility, not government responsibility. People

should not over-drink, over-smoke, over-eat fatty food, over-sit and live sedentary lifestyle, over-fight and get into frequent rumbles, etc. Pharma companies exist because there is a demand for them, the same way that beer, burger and cellphone producers exist because there is a demand for them. When medicine prices are high, blame the govt. high and multiple taxes on drugs, blame the lack of competition among pharma companies because of govt. bureaucracies. Soooo many multinational pharmas, the innovator ones especially, are not yet here in the Phils. -- Nonoy

Health care is also a government responsibility, but the policies must be salutary and not detrimental to general welfare. Just like what Gene said, it should not be a band aid approach. So, for me, government's role is not really to regulate and restrict but to facilitate access to high quality health care with lower costs for all. -- Elizabeth

Ok, I forgot to add in my earlier reply to Gene that government has secondary responsibility to health care. Like in cases of pandemic and outbreak of contagious diseases. In the absence of such health emergencies, government should back out, allow more competition among private hospitals and clinics, more pharma and drugstore companies, etc. When one or some pharma companies introduce fake and substandard medicines that can result to more disease, if not death to patients, government comes in to enforce the rule of law -- no killing, no harming, no stealing, etc. -- Nonoy

4. Discount cards vs. discounted competition

09 July 2009, http://www.thelobbyist.biz

In a competitive business environment, enterprises resort to various forms of competition in terms of (a) quality (who has the most durable, most reliable, most effective, safest) and (b) price (who has the cheapest, most cost-effective).

More players, more competition, more marketing schemes and more price discounts promo. Ultimately, the consumers will benefit because they will have lots of options and choices among the various producers and suppliers of the products that they need based on their particular tastes, preferences, needs and budget.

The proper role of the government therefore, is to encourage more competition among different enterprises and producers, not stifle it. And for government to successfully encourage competition, all it has to do is practically do nothing. Do not over-regulate. Do not bureaucratize. Do not impose high and multiple taxes and fees. Do not intervene anytime for any alibi. Just step back and watch for whoever is doing foul and harmful schemes. Like producing cheap but poisonous food and drinks, cheap but structurally defective houses, cheap but fake and substandard drugs. People will really appreciate it when government comes in and intervene in cases like these because there is physical harm being done or about to happen to the public.

Recently, discount cards and coupon promos by some drug manufacturers became a negative public issue. The issue is that if those pharmaceutical companies are capable of selling their drugs (patented or generic) at 30 to 50 percent discount or higher to those who hold their discount cards, why not make it a “universal” price for all consumers, with or without a discount card. Why give those discount cards only to doctors in expensive clinics and hospitals for their rich and

the middle class patients, why not give the same privilege also for patients who cannot afford to see a doctor.

Since there is obvious “class” discrimination among rich and poor patients, government should come in and mandate or force those drug companies to remove those discount cards altogether and sell their drugs at the existing discount price.

This does not seem to fall in the above definition of where government is expected to keep out or come in. There was no harm to the public when some companies would give price discounts to patients who voluntarily signed into some discount cards. The patients signed in voluntarily like they sign in to their yahoo or gmail or facebook account. The service provider – web-based email or social networking or pharma company – asked the person to give his/her name, age, etc. in exchange for a particular favor, like free email account or highly-discounted medicine prices.

Should the State, through the Department of Health (DOH) and/or the Department of Trade and Industry (DTI) and other government agencies devote their thin resources into coercing companies to another set of price control, then monitor for their compliance or non-compliance, then wait for the “offending” parties’ position paper in a public hearing, then prepare charge sheets and go to the courts if necessary. Is this the right way to spend taxpayers’ money?

It is true that those discount cards may be used by the issuing pharma companies for their “intelligence gathering”. If those pharma companies will distribute their discount cards to all doctors nationwide, let them continue their marketing promo. Other competing pharma companies can bring down the prices of their drugs without discount cards, threatening the marketing promo of the earlier companies that issued discount cards.

Whatever dynamics and counter-promos in quality and price

competition among the various enterprises, the State should get out of such deals. By keeping out, the State is indirectly inviting more pharma companies to come in, both domestic and multinationals, to launch their own promos, and ultimately the patients and their families will benefit.

The State should reserve its coercive resources in tracking and controlling those pharma companies that produce and/or import fake or substandard drugs because of the harm they bring to the public. For these companies, they can always price their drugs just 1/5 of the supposedly comparable drugs because the former just used flour or any cheap and medically useless substances in producing their own “drugs”. Isn’t this a better use of the taxpayers’ money?

There are still so many multinational innovator pharma companies abroad that are not yet in the country that can help increase competition. These multinationals are global corporate brands that are too scared to be involved in even a single case of producing fake or substandard or ineffective drug. Why should the Philippines be satisfied with the current 30 to 40 multinational pharma companies and about the same number of reliable domestic pharma companies, when there is a potential of 200 to 500 reliable companies who can offer more choices for the Filipino patients?

The State, through the Department of Finance (DOH) and the Bureau of Internal Revenue (BIR) should also consider cutting drastically the various taxes and fees that they impose on medicines and active ingredients.

There is nothing to fear in discount cards. We should be afraid in discounted competition instead. Monopolists, oligopolists and political rent-seekers thrive in an environment of discounted and limited competition.

5. Drug pricing and IPR on facebook

23 July 2009

The other day, I posted some of my thoughts on drug price control in the Philippines in my facebook status. I got several comments after that. The one with the most comments was Francis Bonganay. He gave me permission to post his comments in this compilation in my blog. Here's the compilation of such thread:

With drug price control, if I am a pharma company with a revolutionary and very effective drug against say, cancer, but the drug is expensive, I won't bring that drug to countries that have official drug price control policy. I will be seen there not as a revolutionary innovator but as a blood-thirsty, profit-hungry multinational-capitalist firm. -- Nonoy

Are you saying that price control is crude way to control the price of drugs? Or that government should not ever control the price of drugs (even if the price in its jurisdiction is significantly higher than in other jurisdictions)? -- Boying

Government should not ever control the price of drugs because pricing actually serves a purpose in the economy. It allows the supply of drugs to remain available when it is needed. This is why medicines in a hospital are usually 3x the price of drugs found at the store. If it wasn't, people would buy from there first and the hospital would have shortages for their patients. Now, to keep pricing down, the government should also not ever enforce copyright laws. -- Francis Bonganay

Price control distorts market signals that direct producers use to direct their business. While favoring consumers (especially the poor), price controls in the end will result in negative outcomes as its stifles competition by removing the incentive to innovate and discouraging new entrants. – John

Thanks. Price control is often driven by envy, not rational thinking. For instance, currently there are 200+ different drugs against hypertension, prices range from P3/tablet and up, but people are so fixated with Norvasc (P44/tablet), they don't consider the 200 or so competitor drugs that are priced lower. So price control is on Norvasc. -- Nonoy

If all markets were like that you wouldn't have any money to develop it in the first place! -- Patrick

Not true. If you actually did an audit on pharmaceutical R&D, you'd find that almost 80% goes to administrative overhead, government lobbying (and red tape), and an extremely costly trials system… once more organized by the govt. – Francis

Currently all medicines vs. AIDS can only keep the virus at bay, not really kill it. If I am capable of inventing a medicine that can really kill the virus but other companies will say, "your cost of R&D is yours alone but your successful invention is also my invention", then why would I invent it? If your figure of 80% of R&D is admin and unproductive costs is correct, then why don't those tens of thousands of generics manufacturers become innovators too, and make money early instead of just waiting for the drug patent to expire? -- Nonoy

Because the government doesn't like it when there are drugs out there without their holy stamp of approval (like recreational pharmaceuticals). Hence the tests and lobbying required. Don't forget the whole patents thing if you ever have a similar molecule in your lab.
http://mises.org/article.aspx?Id=641&month=30 – Francis

It's the desire of the innovator company that its invention will be protected from poaching and being claimed as "that great invention is mine too" by any company. As long as this protection can be assured, by govt. or NGOs or private

contracts, no problem, provided the innovator should be encouraged, and protected, not discouraged. Otherwise, societies will be full of copycatters only, very little or few innovators. -- Nonoy

Yeah, its the "common sense" idea that everyone has. Omigod! No protection? Who will want to do stuff if everyone is gonna copy myself. That's why its real hard to sell the idea that "No, with all that protection and patents gone there will be MORE INNOVATION." -- Francis

Most inventors and authors are more than willing that their intellectual output will be shared immediately to everyone for free. I write an original article based on a book that I have read or a conference that I have attended, I post my article in my blog, everyone else can read and see it for free. Fine. There is very little cost for me to bother asking people to "pay" for my article. The cost of enforcement is million times higher than whatever projected benefit. But for those where costs are very high and they are not willing to share their invention for free, then they should be respected. -- Nonoy

I think the big contention is not property rights, but enforcement of intellectual property. -- Francis

Private property ownership is important under capitalism. Absence of private property, through forced collective property ownership, means society is under socialism. If people want enforcement of their IPR -- say a fee for every downloaded article from the author's website, then there is a market for that. People who think the author really makes sense and the fee is affordable, they will pay.

The same logic for drug invention and patent applies. If people think the drug by the innovator company is too expensive and there are alternative drugs, they will boycott that drug. If they think that drug is too life-saving while other alternative drugs are noteffective, then they will pay.-- Nonoy

6. MRP, GMA, DOH-K

26 July 2009

It is said that in a welfare state, politicians are well, taxpayers pay the fare. In the case of the health sector, often an emotional subject, politicians are not far behind.

In the current debate on drug price control or maximum retail price (MRP) as stated in the new law, acronyms of big politicians are indicated if not implied.

MRP becomes "Mar Roxas for President", in reference to Sen. Mar Roxas who authored the cheaper medicines law in the Senate and is running for President in the elections next year. It was his strong pressure during the Congressional Oversight Committee on the cheaper medicines law that forced the Department of Health (DOH) to produce a list of medicines to be issued the MRP or price control.

GMA now becomes "Government-Mediated Access" price of the medicines that have voluntary price reduction by their multinationals manufacturers. GMA of course, refers to the President, Gloria Macapagal-Arroyo. The list of drugs under GMA was released today (or perhaps yesterday) in big newspapers. Tomorrow will be a very big day for the President when she delivers her 9th and last State of the Nation Address (SONA) in her 9 years in power.

The DOH Secretary, Sec. Francisco T. Duque III, has his own motto for the Department even before the current drug price control debate. The motto is: “OK-DOH-K!”

Which sounds like "OK Duque".

Politicians really tailor many things including health issues, to their political interests.

(7) Health politics

28 July 2009

I am thankful to the DOH that I've been a part of the DOH Advisory Council on price regulation -- a multi-sectoral, multi-interest body that deliberates on whether government should dip its hands in setting or dictating the price of certain medicines, on whether to allow or restrict drug discount cards, and related topics. The DOH's hands are tied here because the Cheaper medicines law mandates it to take up such matters.

I perfectly remember that the subject of voluntary drug price reduction was extensively discussed during the 4th and 5th Council meetings last month, and I realized that for the first time perhaps in the history of the Philippine pharma industry, the multinationals and Filipino pharma companies were united -- in opposing mandatory government price control.

Last Saturday, July 25, the Advisory Council released its first Resolution, "Implementing the voluntary price reduction for at least 16 molecules (or 41 drug preparations)". It was signed by various stakeholders and participants that regularly attend the Council meetings. I wasn't there because the schedule of the meeting and announcement was moved from 1pm to 10am, and I have an obligation for my daughter in the morning of that day.

The big problem in the implementation of 50 percent price cut (or any other rate) are the small drugstores in the provinces which do not have computerized system in tracking their inventories, sales, orders, and so on. Otherwise, the big drugstores (Mercury, Watsons, PITC Pharma, etc.) can easily comply within the 1 month transition period (August 15 to September 15) before penalties for violation will be implemented.

The list of medicines under voluntary price reduction was advertised in big newspapers last Sunday. But politics set in, as usual. What could be plain "voluntary price" became "Government Mediated Access" (GMA) price, referring to the initials of the name of the President. Which shows once again the ugliness of government intervention. When government comes in, there are always "bahid politika" or political motives, and there are always politicians taking the undeserved media credits.

In reality, government produces not a single tablet, not a single medicine. Government only produces regulations, prohibitions and lots of paper work that all private enterprises (from barber shops to pharma companies) must comply.

When my brother was still undergoing chemo treatment (prostate C), one injection was worth P25,000, nearly P3,000 of which was VAT alone. Eight (8) or more treatments, not effective enough because the cancer virus has spread to his body already. A last-attempt chemo just to prolong his life was worth P90k (of which around P10K was VAT alone). Days before his death, his pain was beyond description.

Cancer and Taxes, they have one similarity: they both suck, they both kill. I know of some rich people who have cancer. They can afford even the most expensive medicines, even the most expensive doctors. But current breed of many medicines are not powerful enough to beat and kill cancer (or AIDS and Alzheimers). So they die quick once the virus spreads in their body.

Some NGO leaders in our local health coalition in Manila portray me as a "traitor" for consistently opposing government price control, government confiscation of private property in IPR. But, I sincerely believe in medicine innovation. Only new, revolutionary, more powerful, real killer drugs of killer diseases can save lives. The generics and cheaper versions can follow later.

8. Double price control

10 August 2009

Senior citizens (60 yrs old and above) and persons with disabilities (PWD, like blind, mute) are entitled to 20 percent discount on medicines. That's price control #1. Then there is the government-mediated and government-mandated 50 percent price cut on medicines. That's price control # 2 that will start 5 days from now, August 15.

There have been a number of confusions already on price control #1 alone. Among these are the following:

One, if the senior citizens are buying drugs that are obviously for their grandchildren or for other people, can the drugstore refuse to give the mandatory 20 percent discount? But, there are clear penalties if the seniors will report to the Department of Health (DOH) and the police.

Two, if a person comes to a drugstore and makes signs that he/she is mute and deaf and demand the 20 percent mandatory discount, how will the drugstore staff know that he/she is indeed mute-deaf and not just pretending?

Three, most small drugstores just make 5 to 10 percent profit margin because of stiff competition among them, but they are all forced by the government to give 20 percent discount to PWD and senior citizens, how will they recoup the losses?

When price control #2 is added to the above, here's the result: for certain drugs, a senior citizen or a man/woman on wheelchair can get 20 percent discount on drugs that already have 50 percent forced price reduction!

Example: a drug that originally sells for P20 a tablet, a drugstore that earns a 10 percent gross margin will make a P2 profit. When that drug was put under the mandatory 50

percent price cut. It becomes P10 a tablet. Then another 20 percent discount, the new retail price will only be P8. If a drugstore is to retain its 10 percent margin, it will only have P0.80 gross profit. Where office or stall rental do not come down, where electricity, water, wages and other costs do not come down, making thin profit margins is dangerous to the long-term sustainability of a small business.

So pharmaceutical companies and drugstores, big and small, are wondering how to deal with this kind of double price control and still survive. And, there are uncontrolled taxes and fees on medicines alone, uncontrolled taxes and fees on entrepreneurship and doing business, the government is not budging to reduce or abolish even one of those various taxes and fees.

Business is business. If businessmen lose money somewhere, they have to recoup it elsewhere; otherwise, they better close shop and move to other industries. So the non-senior, non-disabled persons, rich and poor, men and women, will have to bear higher drug prices.

This morning, I attended the DOH Advisory Council Meeting on Price Regulation. The above issues were among those discussed. Well, the term “double price control” was not used or mentioned there, it’s only a term I coined as I listened to the drugstore owners and managers, including hospital pharmacies, and pharmacists.

The big hospitals were represented there – Makati Medical Center, St. Lukes, Asian Hospital, among others. They say that as much as possible, they do not allow the confined patients to buy drugs outside of the hospital so that they can control the use of (a) cheap but counterfeit drugs, and (b) cheap but sub-standard generics with no bio-equivalence tests. When these drugs are used by the patients, either they do not recover fast, and/or develop new diseases, and some of them sue the hospital and their attending physicians.

So the hospital managers ask, “We usually charge higher for drugs in our pharmacies than the drugstores outside because there are administrative costs to us. A nurse will get the blood pressure for instance and the physician or pharmacist will recommend what dosage to give. Will the new drug price control law allow us to charge additional administrative charges for the medicines we dispense to our patients?” To which DOH officials replied “Yes, a separate charge, but the price of drugs under maximum retail price (MRP) should not exceed the prices as announced.”

As a researcher and policy analyst of the effects of various government interventions in the market, I am intrigued by the unfolding of events, even before the actual price control (the second control) will commence.

I have said it before and I will say it again: politicized pricing through government price control, like mandatory discounts and mandatory price reduction, is among the best formula to mess up the economy. Any intervention will require another set of intervention supposedly to correct the wastes and inefficiencies of the earlier intervention.

Elton John sang it appropriately: “It’s the circle of life, and it moves us all…”

9. Innovation, competition and cheaper drugs

2 September 2009
http://www.thelobbyist.biz/

Innovation is always the engine for change and growth in any individual, enterprise or society. Life becomes interesting and exciting only when there is always something new to see and try, something new to sell and buy, even something new to give away for free.

Innovation is encouraged under a competitive environment. When there is no competition, there is very little incentive to innovate. A monopolist that supplies a particular commodity to a community and it is assured of zero competition for the next 20 or 100 years, will have very little incentive to innovate. Why spend money on expensive research and developing a new and better product when consumers do not have any other options anyway except buy their product no matter how lousy it is?

People change, communities change and evolve. Diseases also evolve. What used to be considered by the people as an ordinary flu is now seen as various strains of flu – bird flu, cat flu, cow flu, swine flu and so on. The attitude of people towards diseases also evolve, they become more demanding if not impatient as they assume that new medicines are coming to cure them within a few days and not a few weeks or months.

The traditional sources of medicine innovation are the pharmaceutical multinational corporations (MNCs). These are huge corporations which have the resources and network to test and develop new drugs to respond to different patients with different diseases with different budget. But more local or nation-based pharma companies are also sprouting up, first to develop off-patent and generic medicines, and later on to start developing their own new concoction and medicines which are both safe and effective.

And still slowly emerging, are individual researchers and non-government organizations (NGOs) which have a clear goal and mission to develop new medicines targeting particular diseases for patients in poorer countries and communities.

Among such innovative and tireless researchers and scientists is Dr. Krisana Kraisintu from Thailand. Krisana is one of the Ramon Magsaysay Awardee for 2009, for being the Champion of Scientific Crusade for Affordable Medicines by "producing much-needed generic drugs in Thailand and elsewhere in the world." She joined the Government Pharmaceutical Organization (GPO) in 1983 and led its research department in producing many generic medicines for a wide range of illnesses.

In 1995, Krisana produced the world's first generic ARV, a generic AZT (zidovudine) for HIV that reduces the risk of mother-to-baby HIV transmission. In 2002, she left the GPO and went to the sub-Saharan Africa region, hit hardest by the AIDS pandemic. Among the countries she visited and worked with, "In war-torn Democratic Republic of Congo, she set up a pharmaceutical factory that was able to produce generic ARVs after three years." In Tanzania, she upgraded an old facility to produce not only ARVs but cheap anti-malarial drugs as well. The Inquirer has a special news report about her, "RM Awardee: Cheap drugs for poorest".

Krisana's initiatives are good. Those who have the expertise and capacity to produce more competing products made whether by multinationals or local pharma companies, should join the competition. More competition is always good for consumers and patients.

I would add that local pharmas should aspire to become multinational themselves someday. Like San Miguel, Jollibee, Figaro, SM, and Metrobank, companies that previously were just confined to the Philippines, now selling their world-class products and services in several countries around the world.

Yesterday, I and other NGO leaders under the Coalition for Health Advocacy and Transparency (CHAT), the civil society partner of the Medicines Transparency Alliance (MeTA) Philippines, had a great opportunity to meet up with Krisana. She was joined by the current Director of the Research and Development Institute of GPO, Ms. Achara Eksaengsri.

After an overview of the Philippine health and pharmaceutical situation given by former DAR Secretary and now President of HealthWatch Philippines, Obet Pagdanganan, we had a productive free flowing discussion. Among the topics that we explored were the following.

One, more competition among pharma companies in Thailand than in the Philippines. In Thailand, there are 167 local pharmas and about 500 multinational pharmas operating. In the Philippines, I could count only about 50+ local pharma and about 40+ multinational pharmas. That's from the members of local pharma association PCPI, and mostly multinationals pharma association PHAP. This partly explains why medicine prices in Thailand are generally cheaper than in the Philippines.

Two, there is no drug price control law being implemented in Thailand, but they have issued compulsory licensing (CL) on 7 drugs against hypertension and cancer. The Philippines has current drug price control program but has not issued CL on any essential drugs yet.

Three, there is no single dominant drugstore in Thailand, unlike in the Philippines where Mercury Drugstore corners a big portion of the drug retailing market. The most dominant player usually could set its own price or profit rate much higher than competing drugstores'. Former Sec. Obet's figure is 60 percent share by Mercury, but I think the steady influx of many new drugstore chains like Watsons and The Generics Pharmacy, plus the in-house pharmacies of private hospitals and clinics, should be eating away the market share of Mercury to only 50 percent or less.

Four, both the Thai and the Philippine governments impose taxes on medicines, despite their high profile pronouncements that they want “cheaper medicines”. Thailand has up to 7 percent import tax and 15 percent value added tax (VAT) on medicines. In the Philippines, up to 5 percent import tax on finished products, 3 percent on raw materials, and 12 percent VAT. The latter also imposes VAT on tolling fee which can be claimed as input tax credit against imported drugs’ sale of the tolled product, and VAT on the sale of the tolled product to distributors. Then there are import processing fee, import documentary stamp tax, and local government tax. The government charges the 12 percent VAT on the landed price of imported drugs plus the other taxes and fees. The VAT in effect, is a tax on a tax.

To my mind, both governments – and many other governments – are hypocrites for calling for cheaper medicines but contributing to expensive medicines because of the various taxes and fees they impose on medicines. They treat drugs as no different from alcohol, beer and hamburger that must be slapped with as many taxes as possible.

Five, Krisana says the role of NGOs is very important in their work in Thailand in producing alternative cheaper essential drugs, and she believes the NGOs in the Philippines are also playing a crucial role in health policy debates. She calls the Philippines’ Cheaper medicines law (RA 9502) “the best” law that she has recently encountered.

I fully agree that NGOs and civil society groups have an important role in various public policy debates, especially in health issues. But said NGOs should not behave or expect like they are adjunct or an “annex” of the government, by easily running to the government to seek for more regulations and interventions.

Here in the country, the President who signed the Executive Order (EO) on drug price control as pressured by some

NGOs and media people, is the same witch that created endless political and business scandals that include large-scale corruption charges, the same witch that wants to be the Prime Minister of the country by attempting to bastardize the Constitution so she will be in power as long as she wants.

NGOs and civil society groups should fiscalize the government in power because even the opposition political parties are not really intent on changing certain policies like medicine taxation because they also want to implement the same regulations and taxation once they are in power. Not a single big politician or political party in this country for instance, has proposed to abolish certain taxes on medicines to contribute to cheaper medicines. Civil society groups should take up that role as voluntary representatives of consumers and ordinary taxpayers.

10. Patrick Swayze, cancer and medicines

15 September 2009

Today, the actor of two famous movies "Dirty Dancing" and "Ghost", Patrick Swayze, died. He was 57 years old. He died of pancreatic cancer. He was diagnosed of that killer disease sometime 1 1/2 years ago. And today, a number of my friends in facebook expressed their sadness for the death of this good looking and talented actor. Me too.

One friend posted in her facebook status today this quote from the actor before he died: "I've had the time of my life. No I never felt like this before. Yes I swear it's the truth. And I owe it all to you."

Pavarotti also succumbed to pancreatic cancer. I know of a rich lady here in Manila, a good friend of my sister, had pancreatic cancer. When it was detected early last year, she was on stage 4 already. Within 4 months she died. A famous Filipino action star, Rudy Fernandez, also died of this disease.

Former Philippine President Cory Aquino died of colon cancer just recently. My sister-in-law died of colon cancer too, about 4 years ago. She's the wife of my elder brother who died of prostate cancer a few months after she died.

Some leftist guys push for IPR and patent confiscation of important medicines via compulsory licensing (CL) plus government-imposed price control. They say that many poor people die of cancer and other killer diseases because the medicines against these diseases are expensive, because of the profit-hungry multinational pharma companies that invented those medicines.

Well, cancer and other killer diseases do not choose their victims. Rich and poor, men and women, they die. A number

of rich people also die of those diseases even if they have the money to pay for those expensive medicines. Like Patrick Swayze and Pavarotti. Like former President Cory, action star Rudy Fernandez, wife of super-rich Congressman Charlie Cojuangco, Rio Diaz, who died of breast cancer. Like former Philippine Senator Robert Barbers who died of throat cancer. And even the wife of the owner of Mercury Drug, the biggest drugstore in the Philippines, also died of cancer.

Money can't kill cancer yet. That's why we need more and continuing medicine innovation, and patent-confiscation demand by the left does not help in encouraging medicine innovation. Diseases evolve, people's lifestyle evolve, physician practices evolve, treatments and medicines should also evolve. Demonizing the medicine innovators as blood-hungry multinational capitalists is misguided. They are capitalists, yes, profit-seeking businessmen, and they can only make profit by producing things which are needed by humanity. It's among their incentives for doing so.

People normally would not patronize and buy things and services which they do not need. That is why sustaining many government bureaucracies have to be funded by revenues that are coercively collected from the people, not from revenues based on voluntary exchange.

11. One month of drug price control, initial assessment

18 September 2009

Below is a news report, an initial assessment of a month of drug price control policy by the Philippine government.

Watsons drugstore says business was good, the federation of small and independent drugstores, DSAP, says they're bordering on bankruptcy. Private Hospitals Assn. of the Philippines (PHAP) also complain, while the Pharmaceutical and Healthcare Assn. of the Philippines (PHAP) and the Philippine Chamber of Pharmaceutical Industry (PCPI) have relatively neutral statements.

But for the first time, I read that the DOH, through USec Padilla, is talking to the Department of Finance (DOF) re government taxation of medicines, especially the 5 percent import tax and 12 percent VAT.

The DOF can not just remove the VAT on medicines because you need a new law amending some portions of the National Internal Revenue Code (NIRC) to say that medicines should be exempted from VAT, also amend the tariff and customs code to say that medicines should be exempted from import tax. These cannot be done by administrative measures, only legislative measures. But then again -- if no one will protest and object -- the DOF can possibly issue an administrative order temporarily exempting medicines from VAT, until a new law is enacted. But such law will have to wait for the next Congress starting 2010.

It's important that government double-talk of "cheaper medicines" and expensive medicines via taxation be corrected. Taxes always distort prices upwards. Government can double the taxes on alcohol and tobacco products, but it must abolish the taxes on medicines.

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http://www.businessmirror.com.ph/home/top-news/16196-1-month-after-big-pharma-drug-stores-hospitals-assess-mdrp.html

1 month after, big pharma, drug stores, hospitals assess MDRP

Written by Sara D. Fabunan / Correspondent
Friday, 18 September 2009 04:00

BIG pharmaceutical companies, which feared the worst with the cheaper- drugs law, are slowly seeing a window of opportunity one month after the government fully enforced an executive order implementing the year-old law: the window is in the tradeoff between much lower prices, but bigger sales volumes.

Small drugstores, however, are complaining, and claimed the combination of cheaper prices and the mandatory senior-citizen discounts are driving them out of business.

A similar complaint is being made by hospitals, who said their in-house pharmacies, known to be adding on hefty sums on the usual prices in drugstores outside, have said they lost a vital profit center when the MRDP went into effect on August 15. Some even claimed they took a big chunk of manpower costs from the in-hospital pharmacy profits....

12. When civil society leaders embrace high taxes

18 September 2009

One health NGO leader narrated their campaign experience for the removal of the tax on one anti-cancer (leukemia) drug. They succeeded, he said, and added that it did not result in price reduction; instead, the price of such drug kept rising. So he concluded that only the pharma company, not the patients, benefited from the removal of taxes on medicines.

One of my Filipino friends in California is helping the Books for the Barrios (BftB, www.booksforthebarriors.com). He, his family, some Filipino officemates and friends, solicit and collect thousands of used books and other educational materials, even toys, for elementary-level students in the US, pack them in boxes, ship them to the Philippines. BftB Manila receives those containers of used educational materials.

Those books from America were donated FREE. These will be distributed to public elementary schools in rural areas of the Philippines for FREE.

But when those used books reach the Philippine ports, BftB Manila pays for the following:

1. Customs duties around P65,000 – yes, there are taxes for donated and used books!
2. Customs broker around P60,000 -- an agency that deals everything with the Bureau of Customs (BOC).

The BftB Manila staff who narrated to me that story last year, said that what's worse, donated medicines and vaccines by volunteer medical missions from abroad, many of them are parked at the Customs area to deteriorate. Why?

Various foreign medical missions and volunteers have money for the airfare of the volunteers and shipment of free drugs and vaccines. But they never expected there are high taxes and Customs brokerage to pay for those donated medicines, so they did not bring money for such. Those vaccines are on refrigerated containers that run on electricity. Since they cannot pay the taxes, and the vaccines require continued electricity while the papers and payment are being processed, the BOC personnel disconnect the electricity as electricity charges are being borne by the Bureau. Within hours, those useful, essential, and life-saving vaccines become useless as they need to be kept at a specified temperature.

For the imported anti-cancer drug that the NGO leader above was talking, I think only the import tax (5%) was waived. This tax is collected by the BOC. On top of the import tax, there is the 12% VAT, also collected by the BOC in behalf of the BIR. This bigger tax has to be paid to the BIR even if the import tax or customs duties are waived.

Any company that is the sole seller of a particular product like medicine for a particular disease is called a monopolist, and a monopolist tends to abuse its position by pricing its product at a high level. Government is an example of a monopoly. It can set its price (tax) at any level, like the personal income tax of 32%, corporate income tax of 30%, VAT, documentary stamp tax, and so on.

The solution to a monopolistic industry structure is more competition. Allow other players and producers to come in. There are hundreds of other multinational innovator pharma companies, and several thousand generic pharmas abrpad, that are not in the Philippines yet. India alone has more than 22,000 pharma companies. Its biggest pharma company, Ranbaxy, is not even here when Ranbaxy can put up stiff competition to anybody here, both local or multinational pharma.

I opined that the posting by said NGO leader was to discourage the pursuance of abolishing taxes -- both import tax and VAT -- on medicines. This government hypocrisy should stop. We all want cheaper medicines, so taxes that hike medicine prices, and regulations that kill competition, should be scrapped.

The guy replied that even if the 5 percent import tax was waived, the anti-cancer drug price did not go down by a corresponding 5 percent. So he reasoned out that if the 12 percent VAT will be removed, then the profit of the pharma companies will rise even bigger.

He further argued that when government tax revenues fall, it's the public who will suffer because the government will have lesser money to develop the country.

Typical statist argument. And this perspective is being embraced by many civil society leaders who hate free markets and more competition in the economy. They want more government intervention, regulation and taxation. These civil society leaders come to the defense of the State on high taxes issue, including high taxes on medicines even if said NGO leaders are supposedly campaigning for "cheaper medicines".

Many NGOs receive big funding from the government, national or foreign aid. Such NGOs are not exactly "non-government". They are more of government-funded organizations (GFOs).

13. Patients' vested interest: more choices

22 September 2009

A friend, Winthrop, made a comment to the article by Cito Beltran. Wyn argued that the "mandatory" car for medical representatives ("med reps") is a perk that he feels can be done away with, along with various incentives to physicians/dispensers. And that the current "live rep push-marketing and (effectively) payola incentive schemes cost more."

Middle of last month, there was a social dialogue between civil society groups (including those under CHAT) and the Pharmaceutical and Healthcare Association of the Philippines (PHAP). Officials of PHAP explained their "Code of Ethics" that apply -- with penalties and sanctions to violators -- to their member-companies. Even PRRM chief and former Sen. Bobby Tanada, and former DAR Sec. Obet Pagdanganan, were surprised to hear about the strict code being imposed on member-companies. If companies are not happy with the Code, they can leave PHAP anytime.

PHAP officials and officials of some MNC pharma who were there were emphatic that for payola-type and other unethical promos by pharmas, "at least 85% probability, they are not PHAP members". Personally, I have heard admissions from some local pharma how they go out of their way to attract physicians. Since they are not MNCs and have no global brand or corporate name, it's difficult for them to get physicians' patronage, unlike Unilab, the biggest pharma company in the country.

I guess the use of med reps is inevitable. Unlike t-shirts, shoes, underwear, ballpens, etc., where an ordinary shopper can scrutinize these products in terms of price and quality, medicines are another stuff. Not even the best lawyer or the best solar physicist can analyze the properties and

characteristics of what's inside those tablets, capsules and bottles. So physicians are sort of "guided" by the med reps sent by the drug manufacturers, or physicians are invited by the manufacturers to some continuing medical education (CME) to introduce their new products. There are costs to all those activities, so the producers pass on those costs to us, patients. In addition, because of the growing competitive nature of the local pharma industry (thanks to the generics law), manufacturers have to embark on certain ads and marketing, otherwise their competitors will beat them.

When manufacturers give cars to their med reps, partly this is to protect the quality of the drugs that those sales people bring. Most medicines require a particular temperature control, say below 25 C always. So an air-con car will help preserve the quality of those drugs. If the med reps wait several minutes under the sun to wait for a taxi or jeepney or tricycle, the quality of those delicate medicines may be affected. So patients will not be healed by those sample medicines that lose their efficacy already.

I don't know what else are the other important factors that manufacturers and distributors consider. But let the various players over-spend or underspend if they must, it's their business and it's their money that will be lost if they make bad business decisions. Our business as watchers and researchers of government policies, is to expose and fight those regulations that kill competition.

As consumers, we have our own vested interest – we want more choices. Let there be 200 or 400 different medicines against hypertension, and allow us consumers, our physicians or other health advisers, to decide which of those 200+ medicines will best fit our particular health needs given our budget and other health conditions. Government should not bow to the health militants who want to kill competition via rigid and coercive policies like price control and compulsory licensing.

14. Swine flu, leptospirosis and new medicines

31 October 2009, www.thelobbyist.biz

New and evolving diseases require new and evolving drugs and other medical treatment to prevent such diseases from spreading. The emergence of new environmental problems like prolonged flooding of low-lying areas exacerbates some diseases that were just minor problems in the past, but have become major diseases recently.

In the US, swine flu has killed more than 1,000 people this year, and up to 5.7 million may have been infected in its first few months of outbreak, according to the US Center for Disease Control (CDC). And the current strain may not be the same that was discovered in late April this. US President Obama has already declared swine flu a national emergency, noting that "the pandemic keeps evolving". With such a big number of deaths, this is indeed a troubling disease. The US government has ordered some 150 million vaccines, mainly Tamiflu made by Roche, by December.

Here in the Philippines, there is a leptospirosis outbreak in some areas of Metro Manila and a few other provinces that remain flooded until now, more than a month after severe flooding that occurred last September 26. As of today, nearly 2,200 people have been infected while 167 have already died from the disease. The spread of the disease has been faster over the past few days.

The Department of Health (DOH) is prescribing only one medicine so far, the anti-biotic doxycycline. The agency notes that this medicine is not 100 percent effective. It can only give some protection to infected persons. Besides, in the guidelines it has issued in using this prophylaxis, it notes

several precautions. The medicine for instance, can NOT be given to the following people: pregnant women, women breastfeeding their babies, children below 8 years old. Physician's caution should also be taken if one has liver or kidney disease, and the drug can cause allergy, diarrhea and/or other side effects like esophageal damage. See the list of precautions about doxycycline, http://www.doh.gov.ph/files/dm2009-0250.pdf.

With a rather long list of precautions and prohibitions in the use of the only medicine being prescribed by the DOH to fight leptospirosis, infected patients and their loved ones will only wish that there are other alternative medicines. But what and where are they?

I have noted in my earlier articles before in this column: people's lifestyle evolve, communities evolve, diseases evolve, and so medicines and other medical treatment must also evolve. This requires endless research and innovation, endless invention of new and more powerful medicines not only for old and known diseases, but also for unseen and unknown diseases. Medicine and pharmaceutical research, therefore, should be encouraged, not discouraged.

If more profit for the successful research companies is the main incentive to encourage more companies and scientists to go into this kind of work, then society should give it to them. After all, not all pharmaceutical researches are successful and useful. Majority of such researches are unsuccessful and punched big losses for the companies that undertook those research.

What is important is that more effective medicines for more killer diseases should be invented and be made available to the public. There should be several medicines from more competing companies for each killer disease, so that patients and their physicians can have more choices for the specific needs and health/economic conditions of patients.

Cost or the price of medicine, though an important consideration, therefore, becomes a secondary issue. The primary issue is the availability of more medicines for more various diseases.

Some rich people are willing to become poor just to save or prolong the life of a loved one. And in many cases, money is not the issue or the solution. It is the non-availability of more powerful drugs and vaccines that can save people from killer and ever-evolving diseases. So for some people, they may have all the money in the world but if the drugs that can cure their loved ones are not there, then early death will be certain.

Unfortunately, for many countries in the world including the Philippines, pricing and intellectual property rights (IPR) of medicines have been heavily politicized. Many politicians and the activist public do not ask about more competition in medicines and medicine producers. They ask for quick political fixes to non-political problems like evolving diseases. And this is where long-term problems will crop up someday. The short-term gains of cheaper medicines -- via price control, via patent confiscation like compulsory licensing and "early working" on still patented drugs -- will be defeated by the long-term loss or non-availability of new medicines that will be brought into the market.

It is indeed ironic that the public, the politicians and would-be politicians did not listen to the majority of the sectors – multinational and local pharma companies, hospitals, drugstores, physicians, pharmacists, and a few NGOs – that opposed drug price control policy. And this points to one ugly reality of politics: problems or issues that could be addressed with zero politics have become heavily politicized. For health issues for instance, politicians and the activist media or NGOs who do not produce even a single medicine dictate the policies for medicine innovation and pricing.

15. Alzheimer's and medicine innovation

17 November 2009

In one of my yahoogroups, I learned that a number of my friends (age mid-40s to 50s) have parents who suffer from Alzheimer's disease. It's a "cruel, cruel disease" in the words of one friend, as her mother can hardly remember a number of things about her, about their family, and so on. And I didn't know that AZ is a growing disease among Filipinos. I know that cancer is, along with hypertension, dengue, etc.

One confiscatory policy of the Cheaper Medicines Law is intellectual property rights (IPR) and patent confiscation via compulsory licensing (CL) of a patented drug or vaccine. This scheme is a technical term for saying, "Your huge cost of medicine R&D is yours and yours alone; your losses for unsuccessful research, losses for less saleable medicines are yours and yours alone. But your successful and saleable medicine invention is also MY invention." And the government made it a policy in the new law.

So now the world is facing various diseases, new and emerging or re-emerging diseases. For instance, before that was only "ordinary flu". Later on we have bird flu, cat flu, cow flu, swine flu, etc. Tomorrow we'll have dog flu, tiger flu, horse flu, etc. And people are becoming more demanding. They want to get cured of their debilitating diseases if possible within 1 week, not 1 month, not 1 year, not 10 years. So people demand more powerful, more disease-killer drugs and vaccines. But the medicine innovators, the only companies who can bring such more revolutionary medicines, are being painted as profit-hungry capitalist multinationals, so that their products should be subjected to confiscatory policies like CL and price control.

In such an environment, we are discouraging the innovators from inventing more powerful drugs. But the richer countries respect IPR and patent, so innovation should continue somehow, but such innovators will think twice in bringing their more powerful but more expensive, new medicines, to countries like the Philippines with a nearly socialist medicine policy. So Filipino patients in need of such medicines will have to buy such drugs in other countries like HK, Singapore, Korea, the US, Europe, etc. Which makes treatment becoming more expensive, not cheaper, as envisioned by the new law. The generics manufacturers are fine, they give us cheaper generic, off-patent but useful drugs. But they invent no new powerful medicines. They're no innovators.

People's lifestyle evolve, our communities evolve, diseases evolve, so the medicines to kill or neutralize those diseases should also evolve. More strains of AZ, Parkinsons, cancer, swine flu, leptospirosis, etc. should be emerging. Probably more debilitating and more cruel. The need for more new disease-killer medicines and vaccines should continue, endlessly. And socialist health and medicine policies are not the way to encourage such innovation.

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16. Mutant diseases and turtle research

5 December 2009, www.thelobbyist.biz

The cold season has been in the country for a month now. Diseases that showed up during the warmer months tend to mutate to a “cousin” and slightly different strains during the cooler months. Such is the case of flu and its mutant varieties – ordinary flu, bird flu, cow flu, and swine flu, among others.

This week, both the Department of Health (DOH) and the World Health Organization (WHO) announced that they are tracking the flu virus in the country as it is now flu season in the northern hemisphere and many people are traveling across continents for the Christmas holiday season. Thus, the flu virus can easily mutate as innocent people who contracted the flu but do not show clear symptoms yet move across the northern and southern hemispheres and the tropics. The WHO noted that the strain has been mutating in many countries.

PAGASA reported yesterday that Metro Manila’s recent temperature records were 2 degrees Celsius colder than average temperatures in the past 30 years. It was a cold November and it will be another cold December as the northeast monsoon is surging. Such cooler than average weather means more susceptibility of more people to cold weather diseases.

As public demand for newer and more powerful medicines and vaccines against certain flu strains and other diseases rise, supply of such innovative drugs should also rise. For many diseases, this might be the case. But for some, like HIV/AIDS, disease-killing vaccines are not invented yet. There is turtle-pace in research.

Why is this so, and what are the incentives and disincentives that are hounding the research and vaccine development against HIV? Below are some figures and analysis.

Investment in R&D for HIV Prevention, $ million, 2008

Sector	**Vaccines**	**Microbicides**	***% Dist'n.***
1. Public Sector	731	207	*84.4 %*
U.S.	620	154	
Europe	69	40	
Others	43	12	
2. Philantrophic Sector	104	35	*12.5 %*
3. Commercial Sector	33	3	*3.2 %*
Pharmaceutical cos.	28	*	
Biotechnology cos.	5	3	
Total global investment	**868**	**244**	***100.0 %***

* No investment reported

Source: Jeffrey Harris, "Why we don't have an HIV vaccine, and how we can develop one", Health Affairs, Nov./Dec. 2009, Vol. 28 No. 6.

While pharmaceutical and biotech companies have the expertise in vaccine development and commercialization, and almost all vaccines used globally today come from them, it is notable that private sector R&D investment in anti-HIV is small. How did it come to this situation, considering that AIDS is a high profile killer disease that has victimized thousands of lives already?

Jeffrey Harris, "Why we don't have an HIV vaccine, and how we can develop one", Health Affairs, Nov./Dec. 2009, Vol. 28 No. 6, made these 3 observations why there is low private

sector spending, in anti-HIV/AIDS research. One, political risk. Governments' decisions to implement large-scale vaccination program or not is volatile and uncertain. Two, another political risk, the growing threats of compulsory licensing (CL) against the effective, safe, popular and highly saleable products. Add also drug price control policies that are in place in some countries like the Philippines. And three, scientific risks: all-or-none proposition from vaccine R&D, that an innovator company must spend big and lose big, or earn big, in discovering a very elusive treatment against the HIV scourge.

A combination of various interventionist and statist policies that demonize innovator companies mainly because they are big and are global corporations, is the main reason why there is turtle pace in medicine R&D for both old and new or emerging diseases.

The current drug price control policy that was imposed by both the Department of Health and the Office of the President is now 3½ months old. It should be noted that it was not an ordinary price-freeze type of control, such as the one imposed after the 2 devastating typhoons that hit Metro Manila and northern Luzon provinces in late September to mid-October this year. Rather, it was a coercive and mandatory price cut by 50 percent that targeted medicines against some of the top 10 killer diseases in the country, but medicines that were very popular and highly saleable. An element of envy against successful and innovative products cannot be discounted as the main motive for such price control order by the government.

One danger of such subjective and almost arbitrary declaration of drug price control, is that innovator companies that have more powerful and more revolutionary medicines and vaccines, will not bring their products into the country. There will always be a fear of another round of drug price control policy anytime, without regard for explicit public

health emergencies , but only for consideration of political emergencies by the politicians in power.

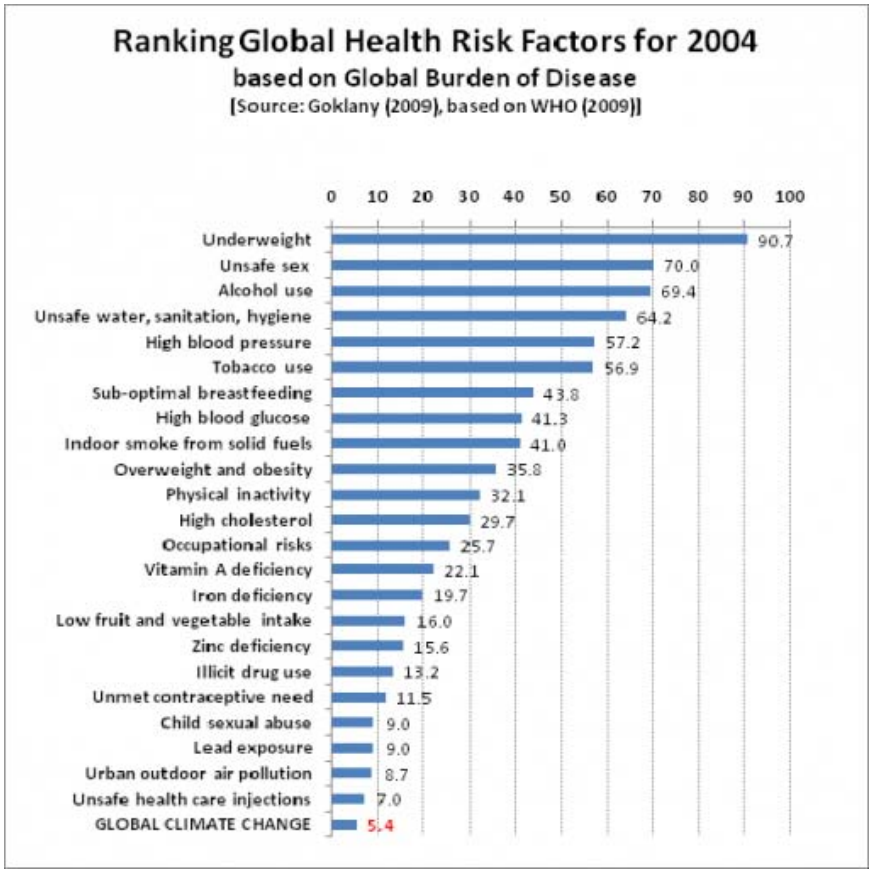
The ultimate loser of this situation will be the Filipino patients. Both poor and rich patients. When we are saving the lives of our beloved family member or friend, money becomes a secondary issue. The main issue is the availability of life-saving drugs and treatments that can kill the diseases that weaken the body and spirit of persons who are close to our heart.

Mutant diseases should be met by mutant medicines and treatment, not by turtle-pace research and treatment, discouraged by heavy politics and political intervention in what are clearly non-political concerns like saving the lives of people who are dear to us.

17. Healthcare is personal responsibility

16 December 2009

I got this chart by Dr. Indur Goklany, an Indian intellectual who wrote the book, "The improving state of the world" published a few years ago.



This chart supports my personal view, that healthcare is first and foremost, personal and parental responsibility. Government responsibility in healthcare is a far second.

Of the top 12 global health risk factors in 2004 in the above chart, 9 are related to personal and parental irresponsibility:

1. unsafe sex
2. alcohol use
3. unsafe water, hygiene
4. high blood pressure
5. tobacco use
6. high blood glucose
7. overweight and obesity
8. physical inactivity
9. high cholesterol

and only 3 are socio-economic, or health risks mainly due to poverty:

1. underweight (malnutrition)
2. sub-optimal breastfeeding
3. indoor smoke from solid fuels (due to lack or absence of LPG, electricity, etc.)

A few weeks ago, I heard a talk by the Medical Director of a pharmaceutical company here in the Philippines. He said that 7 of the top 10 causes of mortality in the country are directly or indirectly related to smoking.

The Top 10 Leading Causes of Mortality, 2000 to 2005 (and probably until now) are:

1. Diseases of the heart
2. Diseases of the vascular system
3. Malignant neoplasm
4. Pneumonia
5. Accidents
6. Tubercolosis, all forms
7. Chronic lower respiratory diseases
8. Diabetis militus
9. Conditions from perinatal period

10. Nephritis, nephritic syndrome

Only #s 5 and 9 above seem to be external or not related to smoking. I don't know which, is the 3rd disease above that is not related to smoking.

Anyway, if most people are dying because of over-smoking, and almost related, due to over-drinking, over-eating fatty food, over-sitting in sedentary lifestyle, etc., then those people really have no right to demand that "healthcare is a basic right" and the government should provide it to them at the lowest cost possible, if not free.

In this case, government therefore, has no justification to declare drug price control, or issue IPR-confiscation policies like compulsory licensing (CL) to have "cheaper medicines" by blaming the multinational pharma companies as the main cause of lack of access to good healthcare by the people.

The best healthcare is preventive, not curative. Hence, the importance of personal hygiene, healthy lifestyle, vaccines, competitive health insurance system, and economic growth that lift people from poverty.

By focusing on the curative aspect of healthcare, the government and some activist health NGOs are deliberately losing sight of the personal responsibility aspect of healthcare, and the distortionary effects of government multiple taxation of medicines, vaccines and healthcare.

18. Drug price control, Sen. Pia style

21 December 2009

I just read that the Congressional Oversight Committee on Cheaper Medicines Law held a committee meeting last Wednesday, Dec. 16, at the Senate. Among those present were Sen. Pia Cayetano and Cong. Arthur Pinggoy, Chairman of the House Committee on Health.

Sen. Pia attacked the Department of Health (DOH) and Sec. Duque for not coming up with a second batch of medicines for drug price control as many people she said, still complain that they don't feel the cheaper prices of medicines yet. She cited the following:

1. Cisplatin 500 mg (anti-cervical cancer), original price at P2,804, price control at P1,125, but can be bought only at P770 from PGH's Cancer Institute.

2. Ramosetron 100 mg (anti-cervical cancer), price control at P860, but can be bought at PGH's CI at only P156.

I do not know how such a big discrepancy can happen. I also wish to see if the drugs cited by Sen. Pia are of the same drug by the same manufacturer and the same distributor. And not one is a generics counterpart, or one is parallel-imported, or other differences.

I think the DOH should conduct a review first of the policy. The drug price control policy is now more than 4 months old (since August 15, 2009). A review is necessary if the policy is beneficial to the public, both short-term and long-term, or not. If it can be proven that it indeed benefited the public, then an extension, if not expansion, of the policy is warranted. Otherwise, the policy should be terminated very soon.

Perhaps BFAD and the DOH can help answer these possible questions in assessing the effectivity or benefits of the policy:

1. Health result of some patients who are chronic or repeated users of certain drugs that were price-controlled?

2. Instances of drug withdrawals, say generics products that cannot compete the sudden low prices of branded and/or innovators drugs?

3. Instances of revolutionary and more powerful medicines against cancer, hypertension, and other killer diseases in the country, that are available in neighboring Asian countries which have no drug price control policy, but are not available in the Philippines?

4. General reaction of other players in the health sector -- drugstores (big and small), hospitals (government and private), pharma companies (local and multinational), professionals' organizations (pharmacists, physicians, nurses, etc.).

I hope that drugs pricing will be depoliticized as soon as possible. When there is heavy politics involved in the pricing of something (drugs, oil, food, house rental, electricity, bus fare, etc.), there is always distortion that will adversely affect the number and quality of players and producers in a given sector.

19. On Health Socialism

28 December 2009

There was a continuing discussion and debate in our UPSE Alumni Association yahoogroups, on health socialism. Some would not consider or admit that drug price control and similar schemes are tantamount to health socialism because the goal of such measures is "to help only the poor have access to medicines."

The current Cheaper Medicines Law (RA 9502) allows "parallel importation" scheme for drugs. Thus, anyone can now import a drug that is currently patented and sold higher in the Philippines, from another country which sells the same drug at a lower price. Thus, importing Pfizer India's Ponstan into the country is technically and legally allowed.

But many doctors, pharmacists, hospital administrators and informed patients are not comfortable with this scheme. Even assuming that the parallel-imported drug is 100% of the same molecule (not counterfeit, not substandard) as the one sold expensively here, there is the question of (a) storage, (b) handling and distribution, and (c) accountability.

Take drug A that specifies it should be stored and handled at temp. range of 15-25 C at ALL times. When it's stored and/or transported at 26 C or higher for 1 hour or more, it will have a lower or lesser effectiveness already. And a patient will either not get well, or develop new disease as the current disease that is supposed to be controlled or killed by a particular medicine, has already managed to mutate inside the body of the patient.

Under a parallel import scheme, the (a) foreign manufacturer, (b) foreign wholesaler or aggregator, (c) local importer and distributor, can be 2 or 3 different entities. They are never the same entity. So if something bad happens to the

medicine being imported and given to the patient, and something bad happens to the patient, who is to be held accountable? A or b or c, or the local patent holder, or the physician and the hospital, or the drugstore, or the DOH?

Saving money is understandable. But saving lives is non-compromisable.

That is why I am not in favor of parallel importation scheme, not in favor of compulsory licensing, not in favor of drug price control, not in favor of government use, etc. ALL of those provisions are now allowed in the Cheaper medicines law. That is why I consider the said law as part of health socialism. The promises are holy and unquestionable – cheaper and affordable medicines. But the schemes used and allowed are generally confiscatory.

The law also does not say anything or amend medicine taxation. Such taxes comprise between 13 to 20 percent of the retail price of drugs. So government is a hypocrite, true blue hypocrite, for calling for “cheaper medicines” but is responsible for expensive medicines by slapping the product with various taxes, as if medicines are like beer and hamburger that should be taxed as much as possible.

So again, my 2 simple proposals to lower medicine prices, both of which were not included, explicitly or implicitly, in the cheaper medicines law:

1. abolish taxes on medicines
2. increase competition among drug manufacturers and retailers.

Part 2

Papers Presented in 2 Conferences

1. Singapore, 2009

3rd Pacific Rim Policy Exchange, October 14 – 15, 2009, Pan Pacific Hotel, Singapore. Sponsored by the Americans for Tax Reforms (ATR), International Policy Network (IPN), Property Rights Alliance (PRA), Acton Institute, and the World Taxpayers Association (WTA).

2. Cebu City, 2010

"**The Impact of RA 9502**", March 6, 2010, Department of Economics, University of San Carlos, Cebu City. Sponsored by the Health Economics Graduate Class 2009-2010, CHAT and Archivus.

Access to medicines through politics: Preliminary assessment of drug price control policy in the Philippines [1]

Bienvenido “Nonoy” Oplas, Jr.

Abstract

This paper analyzes the philosophical, legal and political basis for declaring price control of any commodity in general, and medicine products in particular. It also discusses the evolution of policies and political events that coincide with the declaration and implementation of drug price control in the Philippines, and the policy’s impact on the various players and consumers in the country. The paper concludes that more competition, not more regulations like price control, will bring down medicine prices both in the short-term and long-term. A number of recommendations are presented to certain sectors for their consideration. Some important data and relevant news reports are added as annexes that provide additional proof to the preliminary assessment and recommendations.

[1] Paper presented at the 3rd Pacific Rim Policy Exchange, October 14 – 15, 2009, Pan Pacific Hotel, Singapore. The event was, sponsored by the Americans for Tax Reforms (ATR), International Policy Network (IPN), Property Rights Alliance (PRA), Acton Institute, and the World Taxpayers Association (WTA).

Introduction

These notes and observations are coming from someone who is neither an expert on the science of pharmacology nor the business of pharmaceutical industry. Rather, these notes are from an economic researcher and NGO leader who advocates free market policies and less government intervention in the economy. Thus, technical aspects of pharmacology like the properties of molecules that were subjected to price control, and business models in the global marketing and sales of pharmaceutical products, will not be tackled in this paper. It will focus simply on discussing the merit of free market and competitive pricing, and assessing the impact of price control as experienced in the Philippines.

This paper will be presented under the following sub-topics. *One*, the philosophical basis of price control, the theory and ideology behind this thinking. Two, the legal basis of price control, the provision of the new "Cheaper medicines law" and its implementing rules. *Three*, price-setting under a competitive market and under price control, illustrates a graph to see the difference between the two policies. *Four*, the politics of drug price control in the Philippines, discusses the evolution of events that led to the declaration of the policy. *Five*, preliminary assessment of the impact of price control. And *six*, concluding notes and a short list of important recommendations are being offered.

1. Philosophical basis of price control

Price control of anything – food, oil, medicines, house rental, wages, fare in public transportation, and so on – is rooted on the populist belief that competitive capitalism is not happening in some sectors, that it is not possible to happen even at the theoretical level, that there is always non-competitive business situation somewhere. Therefore, government should come in to protect the poor and marginalized sectors of society.

This is an emotion-laden logic that proves very powerful and irresistible for certain sectors of society. All big capitalists are painted as evil, the poor are being exploited, government is a savior, so the savior should intervene to temper the capitalists and ensure there is justice and equity in society. It hardly enters into public discussion that the supposed savior is itself the main reason why dynamic competition among plenty of players is not happening. Multiple regulations and prohibitions, multiple and high taxes and fees, are seen not as hurdles to more competition among more sellers, but as necessary coercion for economic and political central planning.

In medicines in particular, the multinational pharmaceutical companies (MPCs) are often seen as foreign capitalists whose main business is to make as much profit as possible by bleeding the poor patients in poor countries. MPCs are seldom seen by the activist public as revolutionary innovators who create and produce new medicines for both old and new diseases. The local pharmaceutical companies (LPCs) are seen as some sort of local heroes that must be protected from the onslaught of MPCs which have huge financial and marketing clout globally. Thus, there is implicit desire to see those MPCs to be hit hard as their price-controlled drugs are usually among their most popular, most saleable and hence, most profitable products. An ideology based on deep hatred of capitalism in general, and “big pharma” in particular is fanning the price control groups and sentiments.

Most importantly, health care is seen by many as a “natural right”. Rich or poor, young or old, industrious or lazy, health conscious or health irresponsible, everyone has a “right” to be given quality healthcare by the administrator of the collective, the State. Thus, various measures that will ensure cheap, if not free, medicines and healthcare, should be

instituted by the government, especially if it will hurt the profit-hungry MPCs.

2. Legal basis of drug price control

The current drug price control policy is officially called "maximum retail price" (MRP) under Chapter 3 of Republic Act (RA) 9502 known as "The Universally Accessible Cheaper and Quality Medicine Act of 2008" or Cheaper medicines law for short, signed into law June 2008.

> *SEC. 17. Drugs and Medicines Price Regulation Authority of the President of the Philippines. – The President of the Philippines, upon recommendation of the Secretary of the Department of Health, shall have the power to impose maximum retail prices over any or all drugs and medicines as enumerated in Section 23.*

Details of the above provision are spelled out in Chapter 6, "Maximum Retail Price" or MRP, of the Implementing Rules and Regulations (IRR) of the law, issued in November 4, 2008. Both in the law itself and in its IRR, the list of criteria or factors to consider in issuing price control was long, if not tedious. Section 7 of Chapter 6 of the IRR states that the Factors to consider in recommending the MRP are the following:

(a) Retail prices of drugs and medicines that are subject to regulation in the Philippines and in other countries;
(b) Supply available in the market;
(c) Cost to the manufacturer, importer, trader, distributor, wholesaler or retailer such as but not limited to:

> (i) The exchange rate of the peso to the foreign currency with which the drug or any of its component, ingredient or raw material was paid for;
> (ii) Any change in the amortization cost of machinery brought about by any change in the exchange rate of the peso to the foreign currency with which the machinery was bought through credit facilities;

(iii) Any change in the cost of labor brought about by a change in minimum wage; or

(iv) Any change in the cost of transporting or distributing the medicines to the area of

destination. *(19A2)*

(d) In addition to the immediately preceding section, other such factors or conditions that may aid in arriving at a just and reasonable determination of the MRP shall include:

(i) Marketing Costs (per drug and total global costs);

(ii) Research Costs (local and global/ per drug);

(iii) Promotion Costs;

(iv) Advertising Costs;

(v) Incentives and Discounts;

(vi) Taxes and other fees, impost, duties, and other charges imposed by competent

authority; and

(vii) Other analogous cases *(n)*

When the DOH produced its list of medicines for MRP issuance, the criteria was reduced to only four:

1. Of Public Health concern,
2. If 4-5 times more expensive than ASEAN counterpart,
3. If less than 4 generic counterparts, and
4. If the innovator is the top selling product.

From there, the IMS study commissioned by the DOH and DTI came up with a list of 21 molecules. 11 from DTI study of 100 molecules that make up 70 percent of the local pharmaceutical market, 10 for medicines to treat pediatric cancer (leukemia).

3. Price setting under a competitive market vs. price-controlled market

Under a competitive market, different manufacturers (innovators and generics) produce one or more drugs on the same generic category, and each drug has a particular quality with its corresponding price. Consumers and patients adjust to those prices and quality. Consumers, rich and poor

alike, would reach out for the “better quality” (more effective, more disease killer) ones as much as possible, even if the price may be high. There is ample incentive therefore, for the drug manufacturers to continue innovation and invention of more effective drugs as the patients are demanding it. Other manufacturers would produce non-innovative, older and off-patented products but are sold at a lot cheaper price, and they attract another set or segment of consumers.

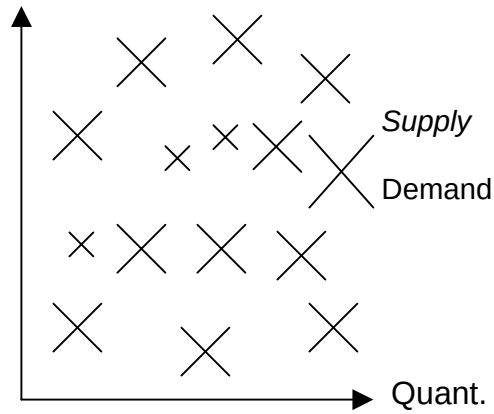
The result is a market with plenty of producers, plenty of consumers, and plenty of “equilibrium prices” or “meeting points” between supply and demand per generic category or per drug molecule. There is no single, centrally-dictated price. This is depicted in the left chart below, case A. The upward-sloping lines represent supply curves by the sellers, while the downward-sloping lines represent demand curves by the consumers.

When a price control is imposed by the government, the market will have one or several flat, horizontal supply curve/s at a price set by the government, and can be called as “centrally-dictated price” for producers. Price ranges and price competition above those horizontal supply curves, even if some consumers are willing to pay at a higher price because of perceived or proven “better quality” drugs, are therefore removed and abolished This new government-controlled price level is no longer set by the various manufacturers competing with each other, and by buyers demanding better quality drugs, and such price can no longer change (upward or downward) any day, anywhere. The only price competition allowed are prices along or below those horizontal supply curves, as shown in case B below.

Chart 1: Price setting among different drugs by different manufacturers in the same molecule category

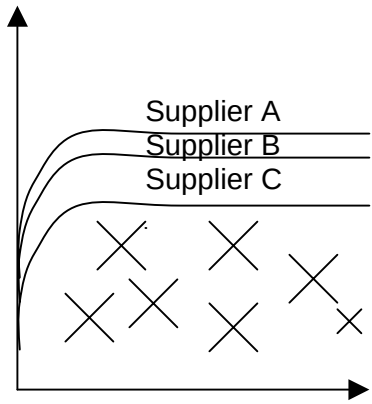
A. Competitive market

Price (per tablet or capsule, etc.)



B. Price Control

Price



So there is a “hollowing out” and emptiness of price competition and price segmentation above the horizontal supply curve. The level of competition among different manufacturers and their respective drug products is reduced and shrunk. And producers of more powerful but more expensive drugs will not be encouraged to bring such drugs into the country because of the constant threat of confiscation by the government of the success of innovation.

With this conceptual framework, we now go to the actual and new experience of drug price control policy in the Philippines.

4. Politics of drug price control in the Philippines

There was no clear and apparent national health emergency in the country at the time the price control provision of the new law was pushed hard, sometime in May to June this year. There was only "political emergency" as the Presidential election, which happens only once every six (6) years, was only one year away. The Senator who was the author of the Senate version of the law, and now the Co-Chairman of the Congressional Oversight Committee on the cheaper medicines law, is a vocal critique of the current administration and is running for President in the May 2010 elections. The new law is among his high profile legislative output and he has put a lot of personal and political stake in that law. Health and medicine prices are both economic and emotional issues that can spark political mobilization.

There are various provisions of the new law that are meant to bring down medicine prices. Among which are the issuance of compulsory licensing (CL) and special CL for certain patented drugs that are popular, highly saleable but deemed expensive. Declaring a CL however, is not easy because there is a clear provision there requiring the existence of a national emergency. Section 10 of the law amends Sec. 93 of the Intellectual Property Code to read as follows:

> *Sec. 93. Grounds for Compulsory Licensing. – The Director General of the Intellectual Property Office may grant a license to exploit a patented invention, even without the agreement of the patent owner, in favor of any person who has shown his capability to exploit the invention, under any of the following circumstances:*
> *"93.1. National emergency or other circumstances of extreme urgency,…*

As mentioned above, there was no national health emergency, so CL cannot be issued even for highly political

purposes. The most graphic provision therefore, that can be invoked that does not require the existence of any national emergency, would be drug price control. It says,

> *Sec. 17…. The power to impose maximum retail prices over drugs and medicines shall be exercised within such period of time as the situation may warrant as determined by the President of the Philippines. No court, except the Supreme Court of the Philippines, shall issue any temporary restraining order or preliminary injunction or preliminary mandatory injunction that will prevent the immediate execution of the exercise of this power of the President of the Philippines.*

Sometime in April and May this year, there were series of meetings held by the Congressional Oversight Committee on Cheaper Medicines Law at the Senate, pressuring the Department of Health (DOH) to issue a list of medicines that can be put under price control. One DOH official observed that “for the Senators and Congressmen in the Oversight Committee, the declaration of price control seems to be the ‘body and soul’ of the new law, the embodiment of political will to implement the law.”

For a better understanding of this policy, below is a brief chronology of the evolution of policies and events that this author can recollect:

Evolution of policies and events leading to the implementation of the current price control or drugs MRP policy.

Date	Events
2008:	
June 6	RA 9502 signed into law by the President of the Philippines
July 4	RA 9502 became effective
Nov. 4	Implementing Rules and Regulations (IRR) of RA 9502 signed, a joint product of DOH, DTI, BFAD and IPO
2009	
January 14, March 26, April 27, June 5 and 19	First five meetings of the DOH Advisory Council on Price Regulation. Issues discussed were price control (MRP) proposed system and policy, criteria in declaring MRP, initial list of molecules and drugs for MRP, to regulate drug discount cards by some multinational pharma companies (MPCs) or not, WHO's national essential medicines facility (NEMF), among others..
May to July	Several committee meetings and growing pressure by the Congressional Oversight Committee on Cheaper Medicines Law, especially by the Chairman of the Senate Committee on Trade and Industry (Co-chairman of the Oversight Committee and principal author the Senate version of the law) to impose price control on certain medicines.
June 8	First official announcement of medicines to be covered by MRP by the DOH Secretary, during a meeting by the Oversight Committee at the Senate. This is 2 days after the 1st year anniversary of RA 9502.
June 16	DOH Secretary submitted to the President a draft Executive Order (EO) containing the list of medicines to be issued drug price control. This list remained secret and was not available to the public as the President was to conduct her own consultations too.

July 2 and 8	Meeting by leaders of some MPCs in Malacanang, with the President on July 8, regarding the impending EO imposing drug MRP.
July 13	Meeting by the Congressional Oversight Committee at the Senate, to investigate what transpired in the July 2 and July 8 meetings with the President. Four invited Secretaries (DOH, DTI, DBM, and the Exec. Secretary) did not show up. Some PHAP officials showed up. Senate President accused Pfizer of "bribery" for its offer to the DOH Secretary to give 5 million discount cards to cover more patients. This became a huge news nationwide. Pfizer denied it was a bribe.
July 19	Deadline for some MPCs to "voluntarily" bring down the prices of their drugs by at least 50 percent, otherwise those drugs will be issued mandatory price cut through an EO to be issued by the President soon.
July 24	Advisory Council for Price Regulation issued Resolution 2009-001, "Implementing the voluntary price reduction for at least sixteen (16) molecules (or 41 drug preparations)" **See Annex 1,** signed by different multi-sectoral leaders (government, industry players, NGOs).
July 27	The President delivered her 9th and last State of the Nation Address (SONA) before the joint Congress (Senate and House of Reps.). EO 821 signed, declaring MDRP or mandatory price cut for 5 molecules. **See Annex 2.**
August 15	Start of implementation of both "voluntary" and mandatory price reduction for the big drugstores. Total of 21 molecules, nearly 100 drugs, covered.
Sept. 15	Start of implementation for said price reduction for smaller drugstores

Some clarification on terminologies.

Before we proceed further, clarification of some terminologies, even acronyms, may be in order. Here are some of them.

Voluntary price cut	This is not precise. Those drugs under the 16 molecules that the Department of Health (DOH) identified (**Annex 1**) will be issued mandatory price cut anyway if the drug manufacturers will not bring down their prices by at least 50 percent. There is a political threat involved. So it is not the typical unilateral, voluntary price reduction because of competition, but price reduction because there will be a coercive EO that will fall upon those drugs if the manufacturers will not cut the prices by 50 percent or more. In addition, once the price is brought down, the drug manufacturers cannot raise the price anytime it wants to, it will need DOH approval for the molecules and drugs to be taken out of the list of price-controlled products.
Government-Mediated Access (GMA) Price.	This is one example of political opportunism. The term refers to drugs that fall under "voluntary" price cut, but the acronym used is that of the initials of the President, Gloria Macapagal-Arroyo. The Office of the President (OP) and the DOH wanted the initials of the President to be equated with lower medicine prices through "voluntary" means.
Maximum Drug Retail Price (MDRP)	This is one example of political tongue-twisting. The actual term used in RA 9502 and its IRR is maximum retail price (MRP).

	But since the main author of the bill in the Senate, and the Co-Chairman of the Oversight Committee that pushed the DOH to produce a list of drugs to be issued price control, was Sen. Mar Roxas, and he is a very vocal critique of the President and he was (then) running for President in the May 2010 elections, the MRP later became known as "Mar Roxas for President". Since the OP and other supporters of the President did not want to highlight further the role of the Senator, so they changed the term to MDRP.
Government **Mandatory** Access (GMA) price	Author of this paper's suggestion, a better term to describe obligatory pricing by the government. The price is mandated by the State and there are penalties for not obeying such coercion. Of course the OP and other supporters of the President do not want to associate her initials to State coercion, so they have to use MDRP and tongue-twist the term actually used in the law and its IRR.

During the 4th meeting of the DOH Advisory Council on Price Regulation last June 5, 2009, presided by the DOH UnderSecretary for Health Regulations, this writer was able to attend. The Advisory Council was created by the DOH last January and it is supposed to be the main consultative body by the Department to get the opinions of various stakeholders on medicine price regulation issues. Judging from that meeting, it was indeed a broad multi-sector body and has a good mixture of participants coming from (a) the pharma industry (local and multinational players), (b) drug retailers, both big drugstores and federation of small and independent drugstores, (c) civil society groups, (d) the multilateral institutions like the EC and WHO, also health

research project funded by foreign aid, and (e) other government agencies like the Department of Trade and Industry (DTI), Bureau of Food and Drugs (BFAD) and the Philippine International Trading Corporation (PITC).

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There was a healthy, frank and fast exchange of opinions among the participants. And as far as this writer can remember, everyone in the room was not in favor of declaring price control, except two leaders of civil society. So the impression of participants on that day, June 5, was that drug price control will not be pursued.

To the dismay of almost everyone, three days after or June 8, during the meeting of the Congressional Oversight Committee at the Senate, the DOH Secretary who attended the Committee meeting, announced that his Department already has a draft Executive Order (EO) imposing price control on certain medicines, and that he will soon submit it to the President for her signature.

It was clear that there was indeed “political emergency” for some government officials aiming for the Presidential and Senatorial/Congressional elections that will happen 11 months away. The succeeding meetings of the DOH Advisory Council until July this year was no longer to get the opinions of the members of that Council whether to go ahead in pushing the issuance of an EO or not, but how to smoothly implement the drug price control policy. The policy has already been firmed up at the top, without any significant consultation with the affected enterprises, due to the growing “political emergency”. The result of the earlier consultations were simply ignored as there was already a centrally-planned decision that needed quick implementation, and the affected players, especially the MPCs and the drugstores, had to accept that political reality.

5. Preliminary assessment of the effect of drug price control policy

As early as June this year, when this writer first attended and heard the (4th) meeting of the DOH Advisory Council on Price Regulation, rumblings of disapproval and discontent of this policy was already very apparent. Not only from MPCs through the Pharmaceutical and Healthcare Association of the Philippines (PHAP), which are the main target of this policy, but also from the LPCs through the Philippine Chamber of Pharmaceutical Industries (PCPI), and the drugstores. Later on, voices of "reserved support" – essentially disapproving but since the policy will be implemented anyway no matter who will oppose it – would crop up from hospital owners and administrators, pharmacists' and physicians' organizations.

Below is an assessment of the initial impact of the policy on certain sectors and sub-sectors.

a. Multinational pharmaceutical companies (MPCs). The main target of this policy and was projected to be the most adversely affected group. The politics of envy, the ideology of anti-global capitalism, the populist demand for cheap if not free medicines from reputable producers, and the political emergency of making political points score with voters by lambasting some big capitalists, have conspired in the success of implementation of this policy. One official of a multinational company replied to this writer,

> "*We need to make clear that this is not just a price control measure. It was a confiscatory price cut of 50%, in many cases for patented products!!! Even in countries that have this type of mechanisms, it usually applies once a patent expires, and only gradually. The impact, of course, is very negative. There are two impacts: the rebates to the trade, which run into the hundreds of millions in pesos for our company alone,*

and the impact in the price cut itself, which will affect both this year and next, also several hundred millions of pesos. Also, it has added a level of uncertainty in our operations, since there is the threat of more price cuts still to come, with no clear understanding of what potential products could be affected, or what is the clear rationale to demand a straight 50% cut."

One unintentional result of the obligatory and mandatory price reduction of some popular drugs by some MPCs, however, is that their affected medicines will now become more affordable even to the lower class. The MPCs will be unintentionally "raiding" a portion of the niche market of many LPCs, the poorer consumers who will now consider buying the "more affordable" products of the MPCs. Whether this will result in increased in overall revenue or not remains to be seen. This is because many poor people do not see a doctor when they are not feeling well, except when their condition has deteriorated that they need to be brought to the Emergency Room of hospitals. If they do not see a doctor for regular check-up, then they may not even become aware of the products of the MPCs.

If the LPCs cannot cope with further drastic price reductions, then they will be forced to either pull out their products that are affected by the obligatory price cut by the MPCs, which reduces their overall market share, or worse, be forced to close shop. Either way, the MPCs' market share will increase. Local operations of MPCs will be affected, but such drop in revenues, if not losses, can be recouped via continued sales in richer countries that frown upon price control policies.

MPCs' revenue from the 10 member-countries of ASEAN (Association of South East Asian Nations) average only around 3 percent of their global revenues in 2007. For the whole of Asia except Japan, they got only around 8 percent of their global revenues. The bulk of their revenues and profit

come from the rich countries of North America, Europe and Japan.

The Philippines' market share is only about 0.5 percent or less of their total global revenues on average. MPCs therefore can afford to endure temporary losses from selling some of their price-controlled drugs in the country because such losses can be recouped from their revenues elsewhere, especially in rich countries. The local and Filipino-owned pharma companies though, except for a few, have no other markets to sell to, and have only limited number of products to sell. So when some of those already limited number of products are hit by huge price cut from competing firms, closure of operation is certainly one possibility.

Local employment of the MPCs is also adversely affected. The affected companies are forced to consider either of two options: (i) Down-sizing, with up to 20 to 30 percent of personnel may have to be retrenched, and/or (ii) Freeze-hiring, which will deprive many qualified people from being employed in the sector, at least temporarily.

b. Local pharmaceutical companies (LPCs). They are also adversely affected, it goes like this. If they used to sell at say, 30 percent up to 49 percent lower than the equivalent products of MPCs under the previous free market set-up, they would find themselves that they are now the "expensive" sellers. So LPCs will be pressured to further bring down the price of their products. If they have some allowance for such further price reduction, say they can further cut the cost of production and marketing (like laying off some workers), well and good. But if none, then either they stop selling their products affected by the price control to avoid losses, or continue selling at a loss, just to retain and protect their overall market share in the industry. Recover the losses by raising the price of other drugs that are not covered by government price control.

One local pharma player replied to this writer's email, he said:

> *"The negative effects, we already know. What we are doing though is to go for other products out of the MDRP range. This I believe is the natural course of events. Likewise we are reviewing the distribution channels and how to become more cost effective. Inescapably, we need to reduce our affected products' prices and operational expenses to still have a viable business."*

The great advantage of capitalism is that entrepreneurs and players always develop high instinct for adaptation and survival. Even in socialist countries like China and Vietnam, competitive capitalism is happening in many sectors and sub-sectors of the economy despite the heavy handed regulations of the State. So, the main goal of enterprises under competitive capitalism is to please customers both in terms of good products or services and reasonable price. Keeping a fat corporate bureaucracy even if revenues are not sufficient is never a goal under capitalism. And the LPCs along those lines.

MPCs have economies of scale in manufacturing and marketing of their products. Production of certain drugs is done in just one manufacturing plant somewhere in the world and marketed and distributed worldwide, creating huge economies of scale. LPCs on the other hand, only have the Philippines as their production base. They do not have economies of scale, compromising their capacity for big price adjustment downwards if needed. But production and marketing technologies keep evolving and improving. Somehow, there is a way for enterprises that keep on innovating to develop their own way of reducing costs while maximizing revenues. Failure to do so will result in either corporate stagnation or bankruptcy.

c. Drugstores. The big drugstores (Mercury and Watsons) only have to worry if the manufacturers and suppliers would give them the rebates quick after sufficient and objective inventory of the affected drugs purchased at the old price were made. Their system is computerized, so the inventory issue is not a problem for them. Smaller drugstores are less modern in their internal monitoring and auditing system as most of them are not computerized. The drug manufacturers also do not prioritize them in rebates.

What actually drains drugstores, both big and small, is the double price control that government has effectively implemented. Senior citizens (60 year old and above) and persons with disabilities (PWD, like the blind, mute, on wheelchair, etc.) are entitled to 20 percent discount on medicines. Then the current price control on the 21 molecules under "voluntary" and mandatory price cut of 50 percent.

Most small drugstores just make 7 to 15 percent profit margin because of stiff competition among drugstores, big and small alike. The double price control of (a) 50 percent price cut under MDRP and (b) another 20 percent discount to senior citizens and PWDs literally and practically squeeze out their already small profit margin. Perhaps these small enterprises recoup the losses by putting higher profit margin for non-prescription drugs, personal hygiene and other consumer items like bath soap, shampoo and tissue papers.

There have been a number of confusions in the implementation of price control #1 (mandatory 20 percent discount for the oldies and PWDs) alone. Among these are:
c.1. Senior citizens buying medicines that are obviously for their grandchildren or for other people like their pregnant daughters or granddaughters.

c.2. Persons who come to a drugstore and make signs and body signals saying that he/she is mute and deaf and demand the 20 percent mandatory discount.

When those two price control policies are added, here's one result: for certain drugs, a senior citizen or a man/woman on wheelchair can get 20 percent discount on drugs that already have 50 percent forced price reduction. If businessmen lose money somewhere, they have to recoup it elsewhere; otherwise, they better close shop and move to other industries. So the non-senior, non-disabled persons, rich and poor, men and women, will have to bear higher drug prices.

d. Hospitals. Hospitals experience difficulty recovering their administrative costs in the process of prescription + dispensation + monitoring + change of medication if necessary. One President of a big private hospital in Metro Manila argued this way:

> *"We are in the business of health care, world class healthcare, not in retailing medicines. We hire good people and give them good pay to educate patients. We not only prescribe medicines for our patients, we also monitor if the given medicines produce the desired results or not. If not, then we have to immediately change the medication to get the desirable health results that we want for our patients. There are costs to this."*

Before the current price control policy, hospitals incorporate such administrative costs in the price of medicines. Now they have to separate the actual price of medicines under price control, and bill separately the administrative costs. Their problem is that many private health maintenance organizations (HMOs) do not want to shoulder such additional bill as they are not covered in the regular health

insurance package. The same problem is also encountered with PhilHealth reimbursement sometimes.

Some NGO leaders requested that patients be allowed to buy medicines outside of hospital pharmacies because prices there are often a lot cheaper than those in hospital pharmacies.

Hospital administrators say that as much as possible, they do not allow the confined patients to buy drugs outside of the hospital to control the use of (a) cheap but counterfeit drugs, and (b) cheap but sub-standard generics with no bio-equivalence tests. When these drugs are used by the patients, either they do not recover fast, and/or they develop new diseases or allergies. Some patients of them sue the hospital and their attending physicians.

Hospital managers also ask, “We usually charge higher for drugs in our pharmacies than the drugstores outside because there are administrative costs to us. A nurse will get the blood pressure for instance, physician or pharmacist will recommend what dosage to give. Will the new MDRP allow us to charge additional administrative charges for the medicines we dispense to our patients.” DOH officials replied “Yes, a separate charge, but the price of drugs under maximum retail price (MRP) should not exceed the prices as announced.”

e. Other industries outside of pharma. The industries often contracted out by both MPCs and LPCs are also adversely affected: no procurement of new vehicles, restrictions on travel for office-based personnel, less frequent or no meetings at all in hotels and restaurants, drastic reduction in procurement of office supplies, etc.

The overall investment environment of the country will be adversely affected. About one month before the declaration of “voluntary” and mandatory price cut in late July, the big

foreign chambers of commerce and industry (US, Canada, EU, Japan, Australia-New Zealand, others) issued a joint statement calling on the President and the DOH not to proceed with drug price control because of the negative image that it will send to foreign investors, not only in the pharmaceutical industry but in almost all other industries.

The implementation of the policy, plus the continued low ranking of the Philippines in various international studies and surveys of economic freedom, ease of doing business, and so on. In the World Bank-International Finance Corp. (WB-IFC) "Doing Business 2010 Report" for instance, the Philippines ranked 144th out of 183 countries surveyed, in the overall ease of doing business.

f. Non-Government Organizations (NGOs). The more established health NGOs were generally in favor of the price control policy. They have lobbied long in the crafting of the law, from patent-confiscating provisions of the new law, to price control provisions. So the implementation of the policy is a victory for them.

At the Coalition for Health Advocacy and Transparency (CHAT), probably the biggest coalition of NGOs in the country engaged in health issues, mainly or partially, there was a debate among member-NGOs whether to support the price control policy, especially the issuance of an Executive Order to force the price reduction by 50 percent. The leadership of the coalition supported the move, while a few, including MG Thinkers, dissented and just issued a clarification position paper.

g. Politicians. The Chairman of the Senate Committee on Trade and Industry, also the principal author of the Senate bill before it became a law, then aspiring to run for President in the May 2010 elections under the Liberal Party, benefited from the price control policy. There was huge media coverage of the Congressional Oversight Committee

meetings on the price control issue, and he got high media and political visibility. The Committee was holding meetings almost every 3 weeks then.

There was one scheduled meeting by the Oversight Committee on September 2, 2009. But the night before, September 1, the Senator announced in a big press conference, that he was withdrawing from the Presidential bid and he was supporting instead, his fellow Senator in the same political party, who is the son of a very famous and well-loved past President Cory Aquino. The next day, September 2 morning, there was a message from the Senator's staff that the scheduled meeting that day is cancelled. Since then until today, there have been no meeting by the Oversight Committee on the price control issue. And this points to one thing: those high profile, sometimes high drama Congressional meetings and public hearing, were done in aid of election, not in aid of legislation, of one particular politician.

The legislators at the House of Representatives who were the main authors of the bill before it became a law, and who were affiliated with the President and the administration, used also the blame-game trend and blamed the said Senator for opposing their original provision creating a separate drug price control body. These legislators and some of their co-authors in the lower House, were later reported to be planning to introduce a new bill that will amend RA 9502 to reiterate creating a separate price control agency in the government.

h. Patients. After all players and political groups in the health sector have spoken, the ultimate judge who will feel the net effect of the policy, will be the patients. There are several impact among consumers and the patients. (i) Savings from expenses on medication, especially for households with one or more family members who are sickly and/or old, so the immediate result is positive. However, (ii) more effective,

more disease-killer drugs that are sold at higher prices, may not be brought into the country by their innovator MPCs. There is a constant fear of being demonized as a profit-hungry devil by the activist media, politicians and NGOs, while at the same time these groups may be salivating to get those more revolutionary drugs at a government-dictated and controlled price.

Or the MPCs may bring in those drugs to the country but not via formal and transparent supply channels. These companies have high “reservation equilibrium price”, which is above the price of the horizontal supply curve controlled by the government shown in the chart above. If this happens, a non-transparent “underground” or “black market” will emerge for such more powerful drugs. These will be sold by some unscrupulous traders and businessmen who will sell the medicines at a much higher price. Or they may not observe proper handling, storage, temperature control, and transport of such important medicines as trading of such medicines are not done in the open. If such delicate medicines are mis-stored at wrong temperature range, their effectiveness as disease-killer will be reduced if not negated. Another possibility is that consumers and patients with desperate need for such more powerful drugs will have to order such medicines from abroad, at a lot more expensive price. The richer ones may have to travel abroad for another set of diagnostic tests with another team of medical professionals who will prescribe such medicine or a new one. Either way, the cost and inconvenience to patients will become higher.

6. Conclusions and recommendations

Government-imposed price controls policy has the undesirable result of institutionalizing and legalizing predatory pricing. By forcing some MPCs to bring down some of their more popular, more saleable drugs, the government in effect has imposed unfair pricing among competing players that can possibly result in the demise of some LPCs which do not have enough leeway in introducing even further price cuts.

This affirms Newton's third law of motion: "for every action, there is an equal, opposite reaction." Translated to economic policy making: for every government intervention, there is an equal, opposite result that needs another intervention.

Politicized pricing through government price control, like mandatory discounts and mandatory price reduction, is among the best formula to mess up the economy. Any intervention will require another set of intervention supposedly to correct the wastes and inefficiencies of the earlier intervention. Elton John sang it appropriately: "It's the circle of life, and it moves us all…"

Lest we be misunderstood, we support the goal of bringing down the prices of medicines – and cell phones, appliances, food, clothing, housing, energy, and so on. The desire to get more of things that are needed by the individuals is a perfectly rational human behavior. The debate therefore, centers only on the ways and policies how to attain such goal.

We believe that the best mechanism to stabilize, if not bring down, the prices of almost anything, is via more producers and sellers competing among each other to get the support and patronage of the public and consumers. Consumer needs, tastes and preferences are not the same. Producers perfectly understand that, that is why there is a wide variety

of products and services for each category of commodity that are available to different consumers with different needs and different budget.

Can the Philippines afford to do away with the multinational pharma?

The answer seems to be a clear No. Per PCPI record, out of the 607 essential molecules, the local pharma companies produce only about 200, so two-third (2/3) of total essential molecules are still being supplied solely by the multinationals in the country.

Transfer of technology from the multinationals to the local pharma companies happens after the drug patent of the former expire, allowing the latter to develop their own brands and generic versions of the off-patent drugs.

But most importantly, multinationals are usually the research-based companies that produce new and more innovative drugs. Diseases evolve, and people are becoming more demanding, they want to recover from their diseases within one to three days whenever possible, and not one week or one month or one year. Hence, the necessity of continued development and invention of more powerful, more revolutionary drugs that only innovator pharma companies can do.

While humanitarian reasons – like giving more access to important medicines for the poor, the sick and the handicapped – provide the convenient excuse for the drug price control policy, it is actually envy, hatred of global capitalism, and political opportunism which are the main reasons for the rushed declaration and implementation of drug price control.

Here are some specific recommendations for each group and institution.

1. Government in general

Government measures and policies that turn off and discourage the entry of more players and competitors – like price control, heavy regulation and bureaucracies, high taxation and disrespect of private property rights like confiscation of important invention – should be avoided. If they have been practiced and implemented already, then they should be discontinued, or at least relaxed.

Government targeting of the most expensive products which are branded, even patented products that are used by the wealthy population that can afford them, is not wise, it is more driven by envy. Such policy has penalized successful brands and distorted the market. Innovator and efficient companies will now be careful not to get to #1 position in Philippine markets for the fear that the government will target their popular products and confiscate their success via price control.

2. Department of Health (DOH)

Here is one advise from an official of one MPC:

> *"If the intention of the government was to really provide affordable medicines for the poor, they should have looked at the list of essential medicines from WHO, which consists mainly of off-patent, older products that are genericized and can be purchased at very low prices, both here and abroad, cut those prices and offer those products. Instead of spending money on expensive advertisements on "MDRP" and "GMA", they could have used that money to advertise those generic alternatives. This is specially true in areas like hypertension, where you can use very inexpensive medicines like diuretics and beta blockers that do a reasonably good job in controllin*

hypertension, and anti-infectives, with first-generation penicillins, amoxicillins and erythromycin, who can also fight most infections.

Instead the government targeted the most expensive products, which are branded, patented products that are used by the wealthy population that can afford them. They penalized successful brands, distorting the market; now we will be careful not to get to #1 position in our markets for the fear that the government will target our products and confiscate our success via price cuts. Furthermore, because they only used IMS data in values, they failed to see that in many cases, the local products were already bigger in volumes than the original product, which was declining in sales year after year."

The DOH should also NOT consider expanding the list of drugs under government price control. This will be tantamount to expanding the distortions in the economy.

3. Congress (House of Representatives and Senate)

Do not pursue the plan to introduce new bills and/or new amendments to RA 9502 that target to:

(a) Create a new drug price control body, replace the current system where the DOH Secretary makes the recommendation, the President signs an Executive Order issuing price control on certain drugs. This is ill-advised. The early results of the current price control policy show that many sectors and enterprises engaged in healthcare are affected more adversely than beneficially.

(b) Require drug manufacturers to submit annual reports of their marketing expenses to the DOH Secretary to monitor such expenses that contribute to expensive medicines. This is a new form of intervention that will definitely discourage

the entry of more players, or push those with wobbly financial condition to close and pack up. Allow private enterprises to decide on their expenses – from R&D to marketing to CME or whatever – so long as the sector is competitive. Those who make unnecessarily high expenses .

(c) Introduce new mandatory discounts for certain groups of people. The mandatory 20 percent discount for senior citizens, and mandatory 20 percent discount for people with physical and mental disabilities, are already pushing some small drugstores and small hospitals into the verge of bankruptcy.

Instead, introduce bills that will remove the various taxes and fees on medicines. This move will knock off at least 13 percent of the retail price of medicines. There are at least 2 different taxes and fees imposed on medicines alone: import tax (3 percent for raw materials, 5 percent for finished products) and value added tax (VAT, 12 percent). There could be other taxes and fees like import processing fee and local government taxes. The VAT is applied as: (landed price + import tax) x 12% = VAT payment. In a sense, VAT is a tax on a tax.

It should be remembered that aside from taxing products like medicines, the government also taxes the various companies engaged in health care -- pharma companies, importers and distributors, hospitals, drugstores and pharmacies.

4. Civil society and the public

Objectively monitor and assess the short-term results and long-term implications of drug price control policy. It is ultimately the public and the consumers, not the politicians, who will suffer from lack of competition among players and lack of choice among drugs, if some players will pull out or

go bankrupt, and/or some drugs are withdrawn from the market because of unrealistic pricing imposed by the State.

So long as alternative drugs, so long as generic competitors are present, then public welfare is assured. Some people complain that even the cheapest generics are still unaffordable for them. Well, there is a price to taking care of our own body and that of our loved ones.

Health care is first and foremost a personal and parental, also corporate responsibility to their employees. People should not over-drink, over-smoke, over-eat fatty foods, over-sit and have sedentary lifestyle, over-fight and have stab wounds occasionally, and so on, then demand that quality health care is their “right” and a government responsibility.

Government responsibility in health care is only secondary to personal and parental responsibility. Government should come in and institute radical intervention in cases of disease outbreak and similar health emergencies. Otherwise, it should step back, it should not over-tax medicines and health enterprises. Allow and encourage more competition among them, so that the public will have more choices. More choice means more freedom.

Annexes.

Attached are some data and relevant news reports that provide additional evidence to the assessment and conclusions.

1. Medicines under “voluntary” price reduction

2. Medicines under mandatory price reduction of 50%, under EO 821

3. Voluntary price reduction, Add-on list

4. Some news reports about drug price control

5. Multinational pharma companies in the Philippines

6. Innovator pharma companies in selected countries not in the Philippines yet

7. DOH Initial List for Drugs Price Freeze (after typhoon “Ondoy”)

Annex 1. Medicines under "voluntary" price reduction
(16 molecules, 41 drug preparations; to be put under mandatory or forced price reduction if not brought down ahead, through an EO)

ACTIVE INGREDIENT/MOLECULE	DOSAGE STRENGTH AND FORM	COMPANY	OLD RETAIL PRICE	GMA PRICE
ANTI-HYPERTENSIVE				
Telmisartan	40 mg tablet	Boehringer	51.5	25.7
	Telmisartan 40 mg + Hydrochlorothiazide 12.5 mg tablet	Boehringer	50	25
	80 mg tablet	Boehringer	89	44.5
	Telmisartan 80 mg + Hydrochlorothiazide 12.5 mg tablet	Boehringer	89	44.5
Irbesartan	150 mg tablet	Sanofi-Aventis via Winthrop	48.76	24.38
	Irbesartan 150 mg + Hydrochlorothiazide 12.5 mg tablet	Sanofi-Aventis via Winthrop	50.26	25.13
	300 mg tablet	Sanofi-Aventis via Winthrop	80	40
	Irbesartan 300 mg + Hydrochlorothiazide 12.5 mg tablet	Sanofi-Aventis via Winthrop	83	41.5
ANTI-THROMBOTIC				
Clopidogrel	75 mg film-coated tablet	Sanofi - Aventis	123.5	61.75
ANTI-DIABETIC/ ANTIHYPOGLYCEMIC				
Gliclazide	30 mg Modified Release Tablet	Servier	15	7.5
	80 mg tablet	Servier	15	7.5

ANTIBIOTIC / ANTIBACTERIAL				
Piperacillin +Tazobactam and all its Salt form	Piperacillin 2 g + Tazobactam 250 mg vial	Wyeth	2175.46	730.2
	4 g + Tazobactam 500 mg vial	Wyeth	4614	1270.06
Ciprofloxacin and all its Salt form	500 mg tablet	Bayer	83.83	41.91
	500 mg tablet (Extended Release)	Bayer	99.23	49.62
	1 g tablet	Bayer	145.1	72.55
	250 mg tablet	Bayer	65.13	32.57
	2mg/ml (100 ml) for injection	Bayer	1884.17	942
	2 mg/ml (50 ml) or 100 mg IV infusion (50 ml)	Bayer	1440.87	720.43
	400 mg (20 ml) for injection	Bayer	3207.17	1603.59
Metronidazole and all its Salt form	125mg/5 ml (60 ml) suspension	Sanofi-Aventis	131	65.5
	500 mg tablet	S-A via Winthrop	23.5	11.75
	500 mg (100 ml) IV infusion	Sanofi-Aventis	379.5	189.75
Co-Amoxiclav (Amoxicillin + Clavulanic acid)	625 mg tablet	GSK	97.75	48.9
	375 mg tablet	GSK	79.5	39.75
	1 g tablet	GSK	142.25	71.15
	600 mg vial for injection	GSK	687.5	343.75
	1.2 g vial for injection	GSK	1156.75	578.4
	Amoxicillin 200 mg + Clavulanic Acid 28.5 mg/5ml (70 ml) suspension	GSK	555.5	277.75

	Amoxicillin 125 mg + Clavulanic Acid 31.25 mg/5ml (60 ml) suspension	GSK	378	189
	Amoxicillin 250 mg + Clavulanic Acid 62.5 mg/5ml (60 ml) suspension	GSK	648.5	324.25
	Amoxicillin 400 mg + Clavulanic Acid 57 mg/5ml (70 ml) suspension	GSK	940.5	470.25
	Amoxicillin 400 mg + Clavulanic Acid 57 mg/5ml (35 ml) suspension	GSK	523.75	261.9
ANTI-NEOPLASTIC / ANTI-CANCER				
Bleomycin and all its Salt form	15 mg vial/ampul for injection	Bristol-Meyer Squibb via Zuellig	9750	3520
Carboplatin	10 mg/ml (15 ml) vial or 150 mg for injection	BMS via Zuellig	3610	1805
Cisplatin	50 mg powder vial for injection	BMS via Zuellig	2804	1125
Cyclophospham ide	50 mg tablet	BMS via Zuellig	33.5	17.5
	200 mg vial for injection	Baxter	698.95	175
	500 mg vial for injection	BMS via Zuellig	649	324.5
	1 g or 1000 mg vial for injection	Qualimed	1155.00	577.5
Etoposide (No innovator locally, NIL)	100 mg tablet	Qualimed	1130.00	565
Mercaptopurine	50 mg tablet	GSK	79	39.5
Methotrexate sodium (NIL)	2.5 mg tablet	Qualimed	23.00	11
	50 mg/ 2 ml vial for injection	Qualimed	612.00	306
Mesna	400 mg ampul for injection	Baxter	369	166.67

Annex 2. Medicines under mandatory price reduction of 50%, under EO 821

ACTIVE INGREDIENT/ MOLECULE	DOSAGE STRENGHT AND FORM	MDRP (Php)
ANTI-HYPERTENSIVE		
Amlodipine (including its S-isomer and all salt form)	2.5 mg tablet	9.60
	5 mg tablet	22.85
	10 mg tablet	38.50
ANTI-CHOLESTEROL		
Atorvastatin	10 mg film-coated tablet	34.45
	20 mg film-coated tablet	39.13
	40 mg film-coated tablet	50.50
	80 mg film-coated tablet	50.63
	Amlodipine besilate 5 mg + Atorvastatin calcium 10 mg tablet	45.75
	Amlodipine besilate 5 mg + Atorvastatin calcium 20 mg tablet	66.25
	Amlodipine besilate 5 mg + Atorvastatin calcium 40 mg tablet	84.42
	Amlodipine besilate 5 mg + Atorvastatin calcium 80 mg tablet	89.99
	Amlodipine besilate 10 mg + Atorvastatin calcium 10 mg tablet	51.13
	Amlodipine besilate10 mg + Atorvastatin calcium 20 mg tablet	73.25
	Amlodipine besilate 10 mg + Atorvastatin calcium 40 mg tablet	91.79
	Amlodipine besilate 10 mg +	91.79

	Atorvastatin calcium 80 mg tablet	
ANTIBIOTIC/ANTIBACTERIAL		
Azithromycin and all its Salt Form	250 mg tablet	108.50
	200 mg/5 ml powder for suspension (15 ml)	427.50
	200 mg/5 ml powder for suspension (22.5 ml)	638.00
	500 mg tablet	151.43
	500 mg vial for injection	992.50
	2 g granules	468.00
ANTI-NEOPLASTICS/ ANTI-CANCER		
Cytarabine	100 mg/ml ampul/vial(IV/SC)	240.00
	100 mg/ml ampul/vial(IV/SC) (5 ml) or 500 mg vial	900.00
	100 mg/ml ampul/vial(IV/SC) (10 ml) or 1g vial	1800.00
	20 mg/ml (5ml) ampul/vial for injection	1980.00
Doxorubicin and all its Salt Form	10 mg powder vial for injection	1465.75
	50 mg powder vial for injection	2265.74

Annex 3. Voluntary price reduction, Add-on list

(Not implemented by the DOH yet, but manufacturers/distributors and drugstores can implement this anytime if they want)

ACTIVE INGREDIENT/ MOLECULE	DOSAGE STRENGTH AND FORM	COMPANY NAME	OLD PRICE	SRP (PhP)
OPIOID ANALGESIC				
1. Fentanyl (as citrate) Injection	50 mcg/ mL, 10 mL ampul	Janssen	1155.00	577.50 (50%)
	50 mcg/ mL, 2 mL ampul	Janssen	304.00	152.00 (50%)
ANTI-DIABETIC /HYPOLGYCEMIC				
2. Glibenclamide	5 mg tablet	Sanofi-Aventis	15.00	8.00
NEUROPROTECTIVE				
3. Citicoline	500 mg ampul	Takeda Pharmaceuticals	498.25	348.80
	1000 mg ampul	Takeda Pharmaceuticals	689.50	482.65
ANTI-THYROID				
4. Thiiamazole (Methimazole)	5 mg tablet	Pharma Link Asia Pacific	10.50	6.90 (35 %)
5. Glucometamine Glucodiamine Nicotinamide Ascorbate	150 mg 30 mg 20 mg	Pharma Link Asia Pacific	16.00	12.80 (20 %)
	60 mL bottle, 187.5 mg/5mL 50 mg/5mL	Pharma Link Asia Pacific	264.75	211.80 (20%)

	25 mg/5mL 120 mL bottle, 187.5 mg/5mL 50 mg/5mL 25 mg/5mL	Pharma Link Asia Pacific	481.75	385.40 (20%)
ANTI-HYPERTENSIVE				
6. Sotalol	160 mg tablet	Bristol Myers Squibb	91.75	76.14
7. Losartan Potassium	50 mg tablet	Chiral	22.80	13.68
ANTI-ALLERGIC				
8. Cetirizine (as dihydrochloride)	10 mg tablet	Chiral	23.02	16.11
NON-STEROIDAL/ANTI-INFLAMMATORY DRUGs (NSAIDs)				
9. Diclofenac Sodium	50 mg tablet	Chiral	7.28	5.10
ANTIBIOTIC/ ANTI-INFECTIVE				
10. Cefalexin (as monohydrate)	500 mg capsule	Chiral	27.72	22.10
11. Clarithromycin	250 mg tablet	Chiral	70.00	36.00
	500 mg tablet	Chiral	117.60	64.00
ANTIFUNGAL				
12. Miconazole	2 %, 15 g tube	Chiral	204.60	163.11
13. Tolnaftate	1 %, 15 g tube	Chiral	151.80	129.03
VITAMIN				
14. Multivitamins		Chiral		

			13.80	12.42
ANTI-INFLAMMATORY/ ANTIPRURITICS				
15. Betamethasone	15 g tube	Chiral	420.00	357.00
ANTI-CHOLESTEROL				
16. Simvastatin	10 mg tablet	Chiral	18.00	12.60
	20 mg tablet	Chiral	21.60	15.12
	40 mg tablet	Chiral	26.40	15.84
ANTI-ANGINAL				
17. Trimetazidine HCl	20 mg tablet	Chiral	18.60	13.02
ANTI-NEOPLASTIC/ ANTI-CANCER				
18. Megesterol Acetate	160 mg tablet	Bristol Myers Squibb	436.75	341.13
19. Ifosfamide	1 g vial	Qualimed	2600.00	2340.00
	2 g vial	Qualimed	5200.00	3510.00
20. Mitomycin	10 mg vial	Qualimed	1430.00	1170.00
21. Erlotinib	150 mg/tab pack of 30's	Roche		
22.Novaldex	20 mg	Asta Zeneca		
VACCINE (FLU)				
23. Oseltamivir		Roche	150.50	107.00

Annex 4: Some news reports about drug price control

(1) Small pharma firms not happy with Maximum Drug Retail Price

By Marianne V. Go (The Philippine Star) Updated August 17, 2009 12:00 AM

MANILA, Philippines - The implementation of the Maximum Drug Retail Price (MDRP) provision of the Cheaper Medicines Act may have the unexpected consequences of once again favoring multinational pharmaceutical companies and squeezing the smaller domestic pharma firms.

This was the wary assessment of Tomas Agana III, president and chief executive officer of Pharex Health Corp., a wholly-owned subsidiary of Pascual Laboratories Inc.

In a press conference, Agana admitted that local drug manufacturers are also against the MDRP which went into effect over the weekend.

http://www.philstar.com/Article.aspx?articleId=496611&publicationSubCategoryId=66

(2) Cheap medicines law registers 90% compliance

By Dona Pazzibugan, Vincent Cabreza
Inquirer Northern Luzon
First Posted 03:21:00 08/20/2009

… The pharmaceutical industry is estimated to lose about P7 billion to P10 billion ($146 million to $208 million) a year in sales, the spokesperson of the Pharmaceutical and Healthcare Association of the Philippines said last month.

Retrenchments by drug firms are the initial consequences of the price cuts for over-the-counter medicines, according to officials and sales representatives of pharmaceutical firms.

Drug manufacturing giant Sanofi-Aventis announced this month that it was reducing its sales force by about 15 percent, even before drug firms had voluntarily slashed prices to comply with the cheaper

medicines law, said a former official of the Sanofi-Aventis Employees Union.

He said the firm cut its sales force by 40 people in December 2008, and was expected to terminate 30 more this month.

Other multinational drug firms feeling the impact of the price cuts have merged operations or dissolved Philippine-based firms, said another official working for pharmaceutical firm Merck-Sharpe & Dohme Ltd. (MSD).

http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20090820-221122/Cheap-medicines-law-registers-90-compliance

(3) Private Hospitals Association may seek injunction vs medicine price cut

By Sheila Crisostomo

(The Philippine Star) Updated August 25, 2009 12:00 AM

MANILA, Philippines - The Private Hospitals Association of the Philippines (PHAP) is studying the possibility of seeking an injunction against the price cut imposed by the government against 43 types of medicine.

PHAP president Dr. Rustico Jimenez said many hospitals have already felt the impact of the price adjustment less than two months after its implementation had begun.

“Many hospitals have already lost a lot of money. I won’t be surprised if some of them would go bankrupt because of the medicine price cut, especially since drug companies have not given them any assurance of rebates,” he said in a telephone interview….

http://www.philstar.com/Article.aspx?articleId=499175&publicationSubCategoryId=63

(4) 8 drugstores probed for violating price cut order

By Sheila Crisostomo
(The Philippine Star) Updated August 28, 2009 12:00 AM

MANILA, Philippines - The Food and Drug Administration (FDA) is now investigating eight drugstores for violating the mandatory price cut implemented last Aug. 15, Health Secretary Francisco Duque III said yesterday.

Four of these drugstores have been served their cease-and-desist order personally by Duque to force them to sell concerned products at the discounted prices.

They are Cheer-up Drugstore, Stardust Drug and Medical Supplies Corp. and Sunburst Drug Corp., all located along Rizal Ave. in Sta. Cruz, Manila, just a stone's throw away from the Department of Health (DOH) central office, and Southstar Drug along Matalino Street in Diliman, Quezon City….

http://www.philstar.com/Article.aspx?articleId=500141&publicationSubCategoryId=63

(5) Price cuts on drugs could lead to retrenchments

KIMBERLY JANE TAN, GMANews.TV
09/07/2009 | 05:13 PM

The reduction in revenues brought upon by the implementation of 50-percent price cuts on 21 essential drugs might force local pharmaceutical firms to trim down their workforces, an industry leader said on Monday.

Asked by reporters during a roundtable discussion at the Diamond Hotel in Manila on the likelihood of retrenchments, Oscar Aragon of the Pharmaceutical and Healthcare Association of the Philippines (PHAP) said, "I think it's a possibility."

Aragon said many of their members, especially the local firms, have been having trouble keeping up with the losses brought about by the price cuts.

"It looks like it's hitting the big multinational companies, but the most affected are actually the local companies," he said.

http://www.gmanews.tv/story/171700/price-cuts-on-drugs-could-lead-to-retrenchments

(6) Pharmaceutical group to maintain drug rates under government mediated access price

BusinessWorld, Tuesday, September 8, 2009

…In a press briefing, Pharmaceutical and Healthcare Association of the Philippines (PHAP) President Oscar J. Aragon yesterday assured that the prices of 38 medicines under the government mediated access (GMAP) price would be maintained.

"We have signed an undertaking with the President that we would continue to lower prices and if we have any issues we must first seek the approval of the Department of Health (DoH)," said Mr. Aragon.

Under PHAP's commitments, companies must first seek the DoH's approval for any rate adjustments in GMAP-covered drugs….

http://www.bworld.com.ph/BW090809/content.php?id=073

(7) Philippines - Drug firms can't take back price cuts

Global Intelligence Alliance, September 11, 2009

The pharmaceutical companies in Philippines cannot unilaterally take back the voluntary price reduction offer for 38 medicines, as they are legally bound to honor the voluntary price cuts offered to the Department of Health (DOH) in August 2009. They need to ask for a review with the government, if the companies have setback in revenues….

http://www.globalintelligence.com/insights-analysis/asia-news-update/asia-news-update-september-11-2009/vietnam-medicine-prices-on-the-rise-again-philippi/

(8) DRUG PRICE REGULATION
Hospitals hike fees to recoup losses

By Dona Pazzibugan
Philippine Daily Inquirer, First Posted 03:50:00 09/16/2009

MANILA, Philippines—The president of a group of private hospitals Tuesday said its members had increased fees to recoup losses from 21 commonly used medicines whose prices were cut in half under the government's drug price regulation scheme.

Dr. Rustico Jimenez, president of the Private Hospitals Association of the Philippines (PrHAP), said member hospitals had jacked up prices of their services because of the government's maximum drug retail price (MDRP) policy.

"We are affected. Where are we going to get the money to pay salaries for our nurses, our pharmacists? We went to the DoH (Department of Health) but we were told, 'It's your lookout,'" Jimenez said in Filipino at a forum on the regulation of drug prices….

http://newsinfo.inquirer.net/inquirerheadlines/nation/view/20090916-225431/Hospitals-hike-fees-to-recoup-losses

(9) MDRP: 30 days after

By SPGamil / De Luxe Drugstore, Daraga, Albay

Wed Sep 16, 2009 11:25 am

The EO is very clear that "Price differentials as an effect of this Order shall be shouldered by the corresponding manufacturer/ trader/importer." However, as of this writing, **I have NOT RECEIVED** any amount that would represent as "rebate" or reimbursement for the price differentials (How about you? Have you received your "check rebate"?). Since my one and only pharmacy is located within 500 meters from the provincial hospital, I have been absorbing the 50% price reduction/differential from my own pocket since August 15, 2009.

It is very disappointing to note that DOH is vigorously pressuring the retail drugstore sector to comply with MDRP but it seemed that they

are half-hearted in running after non-compliant drug companies/distributors on the issue of the "price differential rebate" (which is likewise a clear violation of the law)….

http://dsaph.org/board/viewtopic.php?f=2&t=140&p=640#p660

(10) Hospital owners asked not to raise fees due to drug price cut law
By Marvin Sy
(The Philippine Star) Updated September 17, 2009 12:00 AM

MANILA, Philippines - Malacañang yesterday called on the country's private hospitals to reconsider their decision to raise fees as a response to the mandatory compliance with the Cheaper Medicine Law, saying this would be counter-productive.

Executive Secretary Eduardo Ermita said that the hospitals should also consider the welfare of their patients before making these types of decisions.

"So, instead of thinking about how it will affect their benefits through the gains that they're getting from their operations, they should also consider the welfare of the majority, the patients, most of whom are not well-to-do," Ermita said….

http://www.philstar.com/Article.aspx?articleid=505973

(11) 1 month after, big pharma, drug stores, hospitals assess MDRP
Written by Sara D. Fabunan / Correspondent
Friday, 18 September 2009 04:00

BIG pharmaceutical companies, which feared the worst with the cheaper- drugs law, are slowly seeing a window of opportunity one month after the government fully enforced an executive order implementing the year-old law: the window is in the tradeoff between much lower prices, but bigger sales volumes.

Small drugstores, however, are complaining, and claimed the combination of cheaper prices and the mandatory senior-citizen discounts are driving them out of business….

http://www.businessmirror.com.ph/home/top-news/16196-1-month-after-big-pharma-drug-stores-hospitals-assess-mdrp.html

(12) Private hospitals to raise fees to recoup losses from drug price cut

By Sheila Crisostomo
(The Philippine Star) Updated September 20, 2009 12:00 AM

MANILA, Philippines - Private hospitals will increase their administrative fees to recoup the losses incurred from the medicine price cuts.

Private Hospitals Association of the Philippines (PHAP) president Dr. Rustico Jimenez said this was the consensus of their members during a meeting yesterday in Clark Freeport, Pampanga where they discussed how they could sustain their operations despite the losses.

Jimenez said hospitals would charge a fee every time nurses administer medicine or injection to a patient….

http://www.philstar.com/Article.aspx?articleId=506876&publicationSubCategoryId=63

(13) Cheaper drugs law change eyed

Written by Fernan Marasigan & Estrella Torres / Reporters
MONDAY, 21 SEPTEMBER 2009 22:05

BRITISH pharmaceutical companies are appealing for the amendment of the cheaper-medicines law that significantly reduced prices of drugs for chronic and life-threatening diseases, according to Britain's envoy to the Philippines.

This, as a bill to complement the cheaper-medicines law has been filed in the House of Representatives, seeking to keep drug costs down by requiring drug manufacturers to submit annual reports of their marketing expenses to the secretary of health.

"Lawmakers in the country are bewildered [that] certain medicines sold in the Philippines by a multinational pharmaceutical company are priced higher than other countries like India and Pakistan," said Lakas-Kampi-CMD Rep. Diosdado "Dato" Arroyo of Camarines Sur, author of the bill….

http://www.businessmirror.com.ph/home/top-news/16323-cheaper-drugs-law-change-eyed.html

(14) Palace backs DOH on hospital audit

Written by Mia Gonzalez / Reporter
MONDAY, 21 SEPTEMBER 2009 21:58

THE plan of private hospitals to increase their administrative fees, partly to make up for the shrinking profits from in-house pharmacies that are now forced to comply with the cheaper- medicines law, has sparked a dare by the Department of Health (DOH) for them to open their books to ascertain the urgency of their plan. On Monday, Deputy Presidential Spokesman Roilo Golez said Malacañang fully supports the DOH demand.

The Private Hospitals Association of the Philippines (PHAP) said their move is designed to recoup "losses from the implementation of the cheaper-medicines law."

But Golez said the Palace is not fully convinced that is the reason. "It is possible that [lower-priced] medicine is not the problem. . . . All stakeholders, including hospital administrations, DOH representatives, PhilHealth, suppliers and other representatives of the health-care industry in the country should sit down and have a dialogue."…

http://www.businessmirror.com.ph/home/top-news/16319-palace-backs-doh-on-hospital-audit.html

(15) Don't tax medicines — Pia

September 23, 2009 06:46 PM Wednesday
By: Bernadette E. Tamayo

"There's a lot that can be done to reduce the cost of health care in the country if only the private sector and government would work together," said Ca-yetano, chairperson of the Senate committee on social justice….

"Aside from the Cheaper Medicines Law, the government should consider removing the 12 percent Value Added Tax on essential medicines and medical equipment. Placing VAT on essential drugs is like government earning from the sickness of our people," she said.

She said the government should also consider reducing or removing

import duties on medical equipment being shipped in by both private and public hospitals.

http://www.journal.com.ph/index.php?issue=2009-09-23&sec=4&aid=103559

(16) Hospitals defer fee-hike plan

Written by Sara Fabunan / Correspondent
THURSDAY, 24 SEPTEMBER 2009 00:01

THE Department of Health (DOH) and the Private Hospitals Association of the Philippines (PrHAP) have ironed out their differences, with the DOH pinning down the latter to a promise not to proceed with a plan to increase service fees to cover supposed sharp declines in revenue from in-hospital pharmacies as the cheaper-medicines law is enforced.

Health Undersecretary Alexander Padilla, in a phone interview on Wednesday afternoon, said the agency's meeting with the PrHAP, the Drugstores Association of the Philippines (DSAP) and the Pharmaceutical Healthcare Association of the Philippines (PHAP) was "fruitful," and that the DOH went away with the impression that the private hospitals are willing to forgo their plans….

http://www.businessmirror.com.ph/home/top-news/16447-hospitals-defer-fee-hike-plan.html

(17) Hospitals to rethink hike in medical fees
By Dona Pazzibugan, Charlene Cayabyab
Central Luzon Desk, First Posted 10:08:00 09/24/2009

MANILA, Philippines—Private hospitals may yet reconsider their plan to increase their service fees.

Health Undersecretary Alexander Padilla said a "fruitful" meeting with representatives of the Private Hospitals Association of the Philippines (PrHAP), the Pharmaceutical Healthcare Association of the Philippines and the Drugstores Association of the Philippines discussed the process of giving rebates to drugstores and hospitals for drugs bought at higher prices before the regulated 50 percent price cut took effect last Aug. 15….

http://newsinfo.inquirer.net/breakingnews/nation/view/20090924-226660/Hospitals-to-rethink-hike-in-medical-fees

(18) Rebate guidelines to prevent rise in hospital fees

Thursday, September 24, 2009 | MANILA, PHILIPPINES

THE DEPARTMENT of Health (DoH) will issue guidelines on rebates under the drug price cut scheme to stem the rise in hospital fees arising from the implementation of the cheaper medicines law.

Health Undersecretary Alexander A. Padilla said by phone yesterday that the DoH is holding discussions with the Pharmaceutical and Healthcare Association of the Philippines and the Private Hospitals Association of the Philippines on the guidelines for rebates to drug retailers, mainly drugstores and hospital pharmacies.

On the other hand, Bu C. Castro, hospital group legal counsel, said in a separate telephone interview yesterday that pending the rebates, the adjusted rates would be charged until such time that the losses are recovered, and this could last for six months….

http://www.bworldonline.com/BW092409/content.php?id=074

(19) Small drugstores in Central Visayas found reluctant to comply with Cheaper Medicines Act

PIA Press Release, 2009/09/29

Cebu City (29 September) -- Only 401 out of 1,277 small and medium-sized drugstores in Central Visayas representing 31.4 percent have complied with the implementation of the Cheaper Medicine Act (CMA) after the September 15 deadline imposed by the government to reduce by half the prices of 21 selected medicines.

Bureau of Food and Drugs (BFAD-7) Head Monina Coyoca disclosed that their two-week monitoring of small and medium-sized drugstores and level 1 and 2 hospitals showed less than 50 percent compliance.

Coyoca said those that have not complied do not necessarily mean they refused to heed the government's order but that they are still in the process of doing their inventory and making the necessary adjustments before slashing prices of identified drugs….

http://www.pia.gov.ph/?m=12&r=&y=&mo=&fi=p090929.htm&no=27

(20) GSK, the first MNC to give the "Price Differential" rebate (to me)
by deluxeds

October 1, 2009, … as far as the implementation of MDRP EO 821 is concerned….it is the date I actually received the "price differential" rebate for GSK products included in the MDRP list (ex. Augmentin and Pritor). It is also significant for the drug company, because GSK is the first MNC to give the rebate to an independent pharmacy in my area. It therefore, took them more than 1 month to process the rebate.

Thank you very much GSK for your concern to the survival of **independent pharmacies** in the Philippines!

Pfizer, the 2nd MNC to give the "Price Differential" rebate (to me)

It is typhoon Pepeng signal no.1 and raining hard, but the Pfizer salesman in my area was not hindered by this natural calamity from delivering the "price differential rebate" for their products Norvasc, Lipitor and Zithromax.

Thanks, Pfizer.

http://dsaph.org/board/viewtopic.php?f=2&t=140&st=0&sk=t&sd=a&sid=f25beba4c5388cc722b6189c9bbffa3f&start=30

Some op-ed in Philippine newspapers

(1) Not the solution

Written by Ding I. Generoso / Second Opinion
WEDNESDAY, 02 SEPTEMBER 2009 01:11

While we are liberalizing nearly every industry—from oil to transportation to telecommunications—we are imposing the strictest price controls on the entire health-care sector, from hospitals to pharmaceutical companies.

There is no arguing that health care is an essential service and medicines are essential goods—because good health is essential to all, rich or poor, powerful or powerless. But so are all goods and services that go into the production and provision of health-care goods and services. So is food—in fact, the most essential of all when it comes to sustaining good health for the entire population. Yet we don't impose price control on rice, bread, fruits and vegetables, fish, meat and poultry products, etcetera….

http://businessmirror.com.ph/home/opinion/15439-not-the-solution.html

(2) A brooding volcano

CTALK By Cito Beltran
(The Philippine Star) Updated September 14, 2009 12:00 AM

For sometime now, I have quietly recorded information gathered from many sectors involved in the "medicine" business and I guess it's about time people got an update as to how and what the "Cheaper Medicines Act" and the Maximum Retail Price or MRP on medicines has achieved.

First and foremost, we now realize that "medicines" in the Philippines is not the sole territory or concern of the Pharmaceutical Industry. Legislators and government concentrated on controlling pharmaceutical companies but disregarded the impact of the law on companies that distribute medicines, wholesalers, retailers, hospitals….

http://www.philstar.com/Article.aspx?articleId=505125

Annex 5. Multinational pharma companies in the Philippines

1. Abbot Laboratories, Inc. 2. Alcon Laboratories, Inc. 3. Astra Zeneca Pharma 4. Baxter Healthcare Phils., Inc. 5. Bayer Schering Pharma 6. Boehringer Ingelheim Phils., Inc. 7. Catalent Pharma Solutions 8. Eli Lilly Phils., Inc. 9. Glaxosmithkline Phils. 10. Hi-Eisai Pharma, Inc. 11-. Janssen Pharmaceutica 12. Johnson & Johnson Medical 13. Merck, Sharpe & Domme Phils. 14. Merck (Germany)	15. Novartis Healthcare Phils. 16. Pfizer, Inc. 17. Roche Phils., Inc. 18. Sanofi Pasteur 19. Sanofi-Aventis Phils. Inc. 20. Schering-Plough Corp. 21. Schwarz Pharma Phils. Inc. 22. Servier Laboratories, Inc. 23. Stiefel Phils., Inc. 24. Swisspharma Research Lab, Inc. 25. Takeda Chemicals, Inc. 26. Wyeth Phils. 27. Zuellig Pharma Corp.

Below is a list of other pharmaceutical companies in some rich countries which are not yet here in the Philippines. Not sure if all of these companies are medicine manufacturers or biotech and research companies doing work for innovator pharmaceutical companies. The pharmaceutical industry associations referred to by the websites indicated are affiliated with the International Federation of Pharmaceutical Manufacturers Association (IFPMA, www.ifpma.org). In order to eliminate duplication of counting, companies that are listed in the US for instance, are no longer mentioned or listed in Canada, UK, Sweden, etc. even if these companies have branches or subsidiaries there.

Annex 6. Innovator pharma companies in selected countries not in the Philippines yet

From the US (www.phrma.org)	**From UK** (www.abpi.org.uk)
1. Amgen, Inc.	1. A. Menarini Pharma UK Ltd.
2. Amylin Pharma, Inc.	2. Actelion Pharma Ltd
3. Astellas Pharma US, Inc.	3. Ajinomoto Pharma Europe Ltd.
4. Bristol-Myers Squibb Co.	4. Alexion Pharma UK
5. Celgene Corp.	5. Alizyme Therapeutics Ltd.
6. Daiichi Sankyo, Inc.	6. Allergan Ltd.
7. EMD Serono	7. Alliance Pharma Ltd.
8. Endo Pharma, Inc.	8. Almirall Ltd.
9. Genzyme Corp.	9. Ardana Bioscience Ltd.
10. Hoffmann-La Roche, Inc.	10. Basilea Pharma Ltd.
11. Lundbeck Inc.	11. Bausch & Lomb Ltd.
12. Millenium Pharma Inc.	12. Biogen IDEC Ltd.
13. Otsuka America Inc.	13. Britannia Pharma Ltd.
14. Purdue Pharma	14. Cambridge Laboratories Ltd.
15. Sigma-Tau Pharma Inc.	15. Cephalon UK Ltd.
	16. Chugai Pharma Europe Ltd.
From Canada (www.canadapharma.org)	17. CV Therapeutics Ltd.
	18. Dainippon Sumitomo Pharma Europe Ltd.
1. Aetna Zentaris Inc.	19. Daval International Ltd
2. Ambrilia Biopharma Inc.	20. Eisai Ltd.
3. Axcan Pharma Inc.	21. Elan Corporation plc
4. Charles River Laboratories	22. GE Healthcare Ltd.
5. E-Z-EM Canada Inc.	23. Genus Pharma Ltd.
6. Genome Canada	24. Gilead Sciences Ltd.
7. i3 Canada	25. Brumenthal Ltd.
8. Ikaria Canada Inc.	26. Ipsen Ltd.
9. Inemix Pharma Inc.	27. IS Pharma Ltd.
10. Janssen-Ortho Inc.	28. Leo Pharma
11. Medicago	29. Lily & Co.
12. Merck-Frosst Schering Partnership	30. MedImmune Ltd.
13. Neurolmage Inc.	31. Merck Serono
14. Nucrotechnics Inc.	32. Merz Pharma UK Ltd
15. Oncolytics Biotech Inc.	33. Napp Pharma Ltd
	34. Norgine Ltd
	35. Novex Pharma
	36. Nycomed Ltd
	37. Orion Pharma
	38. Pharmion Ltd

16. Paladin Labs 17. Patheon Inc. 18. Pharmanet LP 19. Ropack Inc. 20. Sanofi Pasteur Ltd. 21. Shire Canada Inc. 22. Therapure Biopharma Inc. 23. Theratechnologies Inc.	39. Pierre Fabre Ltd 40. Pliva Pharma Ltd 41. Procter & Gamble Pharma Ltd 42. ProStrakan Ltd 43. Rosemont Pharma Ltd 44. Siemens Plc 45. Smith and Nephew Ltd 46. Solvay Healthcare Ltd 47. Teikoku Pharma UK Ltd 48. Trinity-Chiesi Pharma 49. UCB Pharma Ltd 50. Vernalis 51. Vifor Pharma-Aspreva

From Sweden (www.lif.se)	**From Finland** (www.pif.fi)
1. Abcur AB 2. AGA Gas AB/Linde Healthcare 3. Air Liquide Gas AB 4. Alcon Sverige AB 5. Biovitrum AB 6. B. Braun Medical AB 7. Ceva Vetpharma AB 8. CSL Behring 9. Diamyd Medical AB 10. Ferring Läkemedel AB 11. Fresenius Kabi AB 12. Galderma Nordic AB 13. Grunenthal Sweden AB 14. Hospira Nordic AB 15. Intervet AB 16. Ipsen AB 17. IRW Consulting AB 18. Janssen-Cilag AB 19. McNeil Sweden AB 20. Merial Norden A/S 21. Mundipharma AB 22. Nordic Drugs AB 23. Novo Nordisk Scandinavia AB 24. Octapharma AB 25. Pierre Fabre Pharma Norden AB 26. G. Pohl-Boskamp GmbH & Co. 27. Quintiles AB 28. Santen Pharma AB 29. SBL-Vaccin AB 30. UCB Pharma AB	1.AKELA Pharma Oy 2. Algol Pharma Oy 3. Alk-Abello Finland 4. Ayanda Oy 5. Berlin-Chemie/A. Menarini Suomi Oy 6. Biotie Therapies Oy 7. Crown CRO Oy 8. Eläinlääketeollisuus ry, 9. Encorium Oy 10. Ferring Laakkeet Oy 11. Oy Ferrosan AB 12. Finn Medi Tutkimus Oy 13. Fit Biotech Oy 14. Fresenius Kabi Ab 15. Galderma Nordic AB 16. Hormos Medical Oyj 17. Oy Leiras Finland Ab 18. Medfiles Oy 19. Oriola Oy Panfarma 20. Parexel Finland Oy 21. Sanquin Oy 22. Oy Stada Pharma Ab 23. Suomen Punainen Risti

Annex 7. DOH Initial List for Drugs Price Freeze

(After the calamity caused by typhoon "Ondoy" last September 25; this list was released by the DOH last October 6, 2009)

1. Ascorbic acid 500 mg tablet
2. Ascorbic acid 100 mg/5 mL syrup, 60 mL bottle
3. Cefalexin 250 mg/ 5 mL granules/powder for syrup/suspension, 60 mL (as monohydrate)
4. Cefalexin 500 mg capsule (as monohydrate)
5. Chloramphenicol 125 mg/5 mL suspension, 60 mL (as palmitate)
6. Chloramphenicol 500 mg tablet
7. Cloxacillin 125 mg/5 mL powder for suspension, 60 mL bottle (as sodium salt)
8. Cloxacillin 500 mg capsule (as sodium salt)
9. Cotrimoxazole: 200 mg sulfamethazole + 40 mg trimethoprim per 5 mL suspension, 60 mL bottle
10. Cotrimoxazole: 400 mg sulfamethazole + 80 mg trimethoprim per tablet
11. Cotrimoxazole: 800 mg sulfamethazole + 160 mg trimethoprim per tablet
12. Lagundi 300 mg tablet {Vitex negundo, L. Fam (Verbenaceae)}
13. Lagundi 300 mL/5 mL syrup, 60 mL bottle {Vitex negundo, L. Fam (Verbenaceae)}
14. Mefenamic acid 500 mg capsule
15. Metronidazole 125 mg base/5 mL (200 mg/mL as benzoate) suspension, 60 mL bottle
16. Metronidazole 500 mg tablet
17. Metroprolol 100 mg capsule (as tartrate)
18. Nifedipine 5 mg capsule
19. Paracetamol 250 mg/5 mL syrup, 60 mL bottle (alcohol free)
20. Paracetamol 500 mg tablet
21. Paracetamol 120 mg/5 mL (125 mg/5 mL) syrup/suspension, 60 mL bottle (alcohol free)
22. Povidone iodine 10% topical solution, 60 mL bottle
23. Salbutamol 2 mg tablet (as sulfate)
24. Salbutamol 2 mg/5 mL syrup, 60 mL bottle (as sulfate)
25. Salbutamol 1 mg/mL (2.5 mL) respiratory solution (for nebulization) unit dose (as sulfate)
26. Sambong [Blumea balsamifera, L. DC (Fam. Compositea)]
27. Vitamin B1 B6 B12 (100 mg + 5 mg + 50 mcg) tablet/capsule

Property Right and Pricing Left Under the Cheaper Medicines Law [2]

Bienvenido Oplas, Jr.

Abstract

Property rights of drug innovator companies so far have been generally respected under the Cheaper Medicines Law. Pricing left though, or taking drug pricing towards a left-leaning policy of price control, has compromised some energy and resources of the health agencies of the government as results of the more than six months old drug price control policy did not produce clear and explicit positive outcomes. Other policies that still advance the spirit and intent of the Cheaper Medicines Law need to be explored instead. Two economic tools were employed in analyzing the policy, namely pricing under free market and under government control, and game theory.

The relationship between political risks and R&D spending on HIV prevention is also discussed. The paper argues that improving the business environment by respecting competitive pricing will attract more players and competitors in the healthcare sector, that this should be prioritized rather than demonizing the existing players. And that healthcare is mainly personal and parental responsibility, government to provide secondary responsibility on a few and targeted groups.

[2] Presented at the forum, "**The Impact of RA 9502**", March 6, 2010, Department of Economics, University of San Carlos, Cebu City. Sponsored by the Health Economics Graduate Class 2009-2010, CHAT and Archivus.

1. Introduction

Republic Act (RA) 9502 or the “Cheaper Medicines Law”, enacted in June 2008, is a long and comprehensive law. It covers 6 main subjects to help bring down medicine prices: (1) amending the Intellectual Property Code (IPC) of the country, (2) drugs and medicines price regulation, (3) strengthening the Bureau of Food and Drugs (BFAD), (4) non-discriminatory clause, (5) amending the Generics Act of 1988, and (6) amending the pharmacy law.

Of these six major headings and chapters, the longest was #1, amending the IPC, occupying nearly one-third (1/3) of the entire law. The second longest chapter of the law is on #2, drugs and medicines price control. Thus, the four other issues or chapters were considered as minor factors to bring down medicine prices.

At the time the law was heavily debated and later enacted, intellectual property rights (IPR)-related topics like compulsory licensing (CL) and parallel importation were rather high on the agenda of public discourses as CL was being used and implemented by the Thai government on some anti-cancer and anti-HIV drugs produced by some multinational pharma companies. Then there was a big debate on the legality of parallel importation and the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights, or TRIPS flexibilities.

Another big debate then was whether physicians should be banned or not, from writing the brand of medicines in their prescriptions to their patients. Later the physicians threatened a “physicians’ or hospital holiday” as a form of protest to the proposal in the bill to disallow them from prescribing a certain brand to their patients, and to prescribe just the generic name of medicines. The legislators relented on this action by the physicians. In the implementing rules and regulations (IRR), only physicians from government

hospitals and other public outlets are barred from prescribing medicine brands, physicians from private clinics and hospitals can do so.

The debate on imposing drug price control in the bill was generally limited on whether to create a new price control body or not. The “naye” won and no new drug price control bureaucracy was created.

After the enactment of the Cheaper Medicines Law (CML), it turned out that drug price control issue would be the main instrument to be used by the government, not CL and other amendments to the IPC, despite the fact that the latter was the original intent of the bill then and that it was the most elaborate topic or chapter out of the 6 topics of the law.

This paper therefore, will focus on drug price control issue as the policy is now entering its 7th month of implementation and no formal assessment report has been issued by the Department of Health (DOH) yet as the main implementing agency, whether the policy has achieved its goal or not.

2. Price control and supply distortion

The purpose of government price control policy is to make prices of certain commodities become “more affordable” to the poor. In this case, drug prices.

The policy is deemed to have short-term and immediate benefit to the consumers, especially the poor. About the long-term costs and benefits of the policy, government policy makers are usually mum and silent about it. These measures are political in nature and hence, on the political consequences in the long-term, “let the next administration take care of them” is the usual mindset.

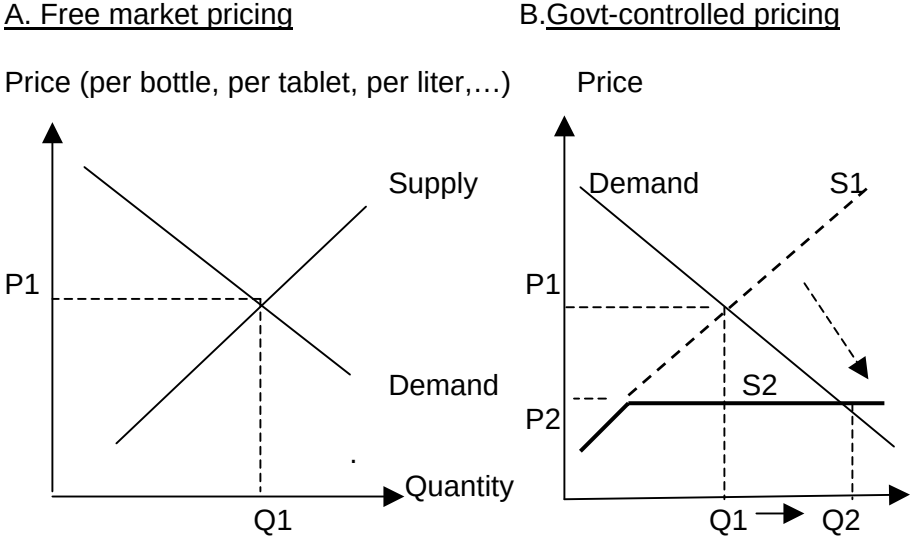
Since the audience of this forum are mostly university students, graduate students of health economics more

specifically, some theoretical discussion of the subject can be introduced.

Under free market pricing, supply meets demand at a price that each seller and each buyer agrees. For instance, a vendor sells mangos at P50 a kilo. Buyers A and B agree to the price and they get a kilo or more. Buyer C does not agree and walks away to find another mango vendor who can sell at only P45 a kilo or even lower. So there is a unique "equilibrium price" for each buyer and seller for each commodity or service sold in the market.

Under government-controlled pricing, any "high" price in the subjective assessment of government officials, should be removed and be forced to a lower level that the same officials deemed to be affordable enough to the poor. Thus, the original supply curve (S1 below) of a particular commodity, in this case, medicines, is arm-twisted to a new supply curve (S2) where a supplier or manufacturer cannot sell beyond such price level.

Chart 1. Comparison of market and government pricing



By forcing the price of a certain commodity, drugs in this case, to go down from P1 to P2 (50% lower than P1), the government hoped that quantity will increase (from Q1 to Q2) as the poor who could not afford P1 would now be able to afford P2.

Nice logic and looks to have good common sense, except that sense does not appear to be common all the time. So let us see if the projected benefit – the poor buy more of the branded essential medicines that were subjected to price control – was attained.

The policy was formally announced in two batches in July 2009. The so-called "voluntary" price cut of 50 percent under the government-mediated access price (GMAP) was announced in July 24, 2009. Then the "mandatory" price cut of 50 percent under the maximum drug retail price (MDRP) was announced in July 27, 2009 under Executive Order (EO) 821, after the President delivered her 9th and last State of the Nation Address (SONA) in Congress. Implementation of both schemes was August 15, 2009.

Again, there was politics involved in such acronyms. "Voluntary" price or GMAP has the subliminal meaning of Gloria Macapagal Arroyo Price. "Mandatory" price or MDRP is nowhere to be found in RA 9502 and its IRR IRR. It is an illegal term, to be strict about it. The official term in the law and its IRR is maximum retail price or MRP, not MDRP. But MRP then was coined by some quarters to mean "Mar Roxas for President" and the Senator was still a Presidential candidate at that time and he was a staunch critic of the President.

And finally, the term "voluntary" price cut is not precise because if the manufacturers of those drug molecules that the DOH has identified will not bring down their prices by at

least 50 percent, there is a political threat that they will be covered by the Executive Order that the President will issue anyway to force the 50 percent price cut.

3. Actual result of price control

Last February 22, 2010, there was a meeting by the DOH Advisory Council on Price Regulation. This writer is a member of the Council and attended the meeting. The Council contains all the major players and stakeholders in the sector: the pharmaceutical companies (local and multinationals), drugstores, hospitals, medical and pharmacist associations, NGOs and patient groups.

The second list of drugs where prices were voluntarily brought down by their manufacturers was presented. Some players and stakeholders also made brief presentations about their experience of the policy after six months. It is notable that after such period, some scattered complaints can still be heard, among them:

1. Small drugstores: Our rebates please! Until now, some pharma companies still did not give us our rebates. And now there is a 2nd batch of price cut, another round of running after our rebates.

2. Medium size drugstores: Suffering from reduced revenues, reduced profit. The quantities sold of price-controlled drugs did not increase, they even decreased. We may be forced to possibly reduce our manpower just to stay competitive.

3. Private hospitals: Cannot pass on the cost of dispensing, monitoring, change dispensing if necessary, of drugs. So we have to raise the fees somewhere.

4. Local pharma: We are slugging out with competition with the multinationals and among ourselves prior to price control.

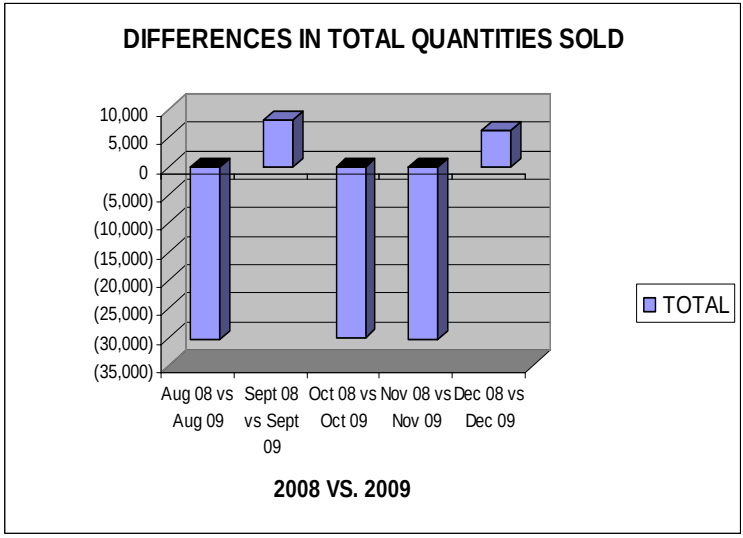
We were forced to further bring down our prices. Also, the labeling requirement should be strictly implemented, those under MDRP should have labels in bottles and tablets, "Under price control: Price should not exceed P____" But the DOH is not strictly enforcing that.

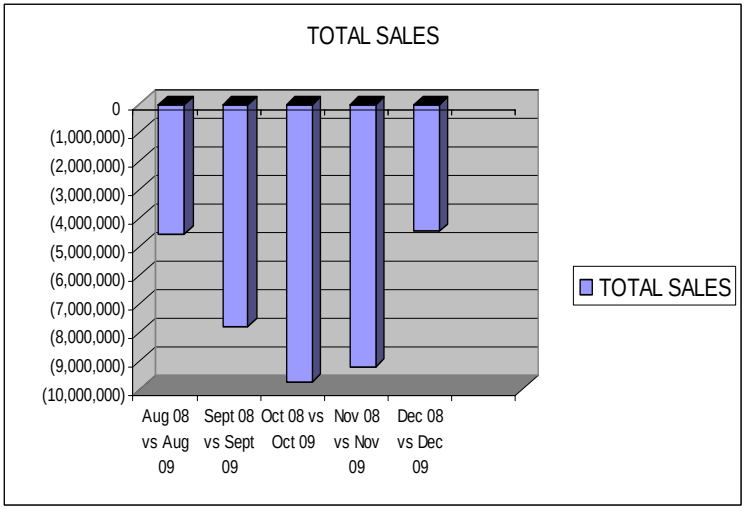
5. Multinational pharma: Sales volume of price-controlled drugs are either stagnant or falling, not rising, which is the target of the law.

6. Patient groups: DOH posters in many drugstores that specify the drugs under price control are absent or not visible to the public.

This writer made the observation during the meeting that the DOH is only making itself the punching bag of complaints of the various sectors, from consumers to drugstores to pharma companies. That unless there is an explicit, categorical result to show that price control has achieved its goal – making the “essential but expensive” branded medicines more affordable to the poor – the DOH should discontinue the policy.

Below is a chart from one presentation during the Advisory Council meeting, from the experience of Manson and Med Express drugstores. It is a comparison of both (a) quantities sold and (b) total sales, before and after the drug price control policy, August to December 2008 vs. August to December 2009.





Source: Ocampo, Leonila, 2010. MDRP/GMAP: Its Effect on Drugstore Operation,

There was a decline, not increase, of 3.4 percent in quantities sold, and 34.3 percent decline in sales revenues. What happened?

There was another presentation from an industry player during the Advisory Council meeting, where one chart showed there was no significant increase in total sales volume of price-controlled drugs in 2009 compared to 2008. And that among originator or innovator brands in particular, there was no increase in quantities sold, contrary to expectations that when the price of innovator brands, including patented ones, are forced to go down to only one-half of their original price, there will be increase access by the poor for such drugs. The same can be said for branded generics.

It should be noted that whatever data on sales volume of drugs by drugstores, are not complete and understated as there are sales of certain drugs and vaccines, innovator or generics, that are done by physicians themselves. Getting those figures is tricky and difficult, but such figures should be substantial.

In further analyzing why the sale of essential branded medicines did not show any increase, Again, it may help perhaps to use another tool in economic analysis, game theory.

4. Game Theory

This is an applied mathematics theory that has been adapted in the social sciences and economics. It is useful in analyzing players and consumers' behavior, and from which, certain insights for public policy can be derived.

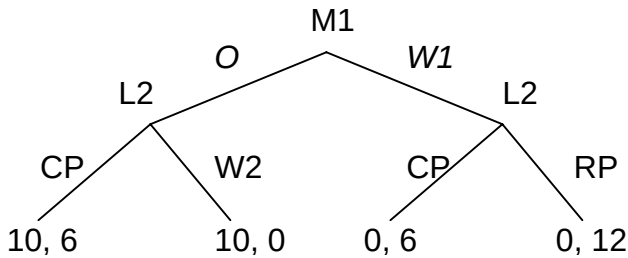
Assume there are two players in a particular drug molecule. Player 1 is a multinational (M1) and player 2 is a local (L2) pharmaceutical company. Before the price control order, M1's price was P20 a tablet and L2's prices was P12 a tablet. That is, L2's prices are 40 percent lower than M1"s.

With price control, M1 was forced by the DOH and the President to bring down its price by at least 50 percent, or down to only P10 a tablet. M1 will have 2 options: obey the order (O), or withraw (W1) the product from the market if it means losses for the company.

Now L2 loses its lower-price comparative advantage as M1's prices are now lower than its price, and M1 has a "better brand" image in the public being a global player. So L2 will have different options: If M1 chooses O, then L2 will either further cut prices (CP) by say, 50 percent (from P12 to P6 a tablet) or withraw (W2) the product if there is no more allowance to make huge price cut without incurring losses.

If M1 chooses W1, meaning the multinational will withraw its product from the market, then L2 will have 2 options: CP if it anticipates that the product pull out by M1 is only temporary and will choose O later, or retain its price (RP) and get bigger revenues.

An extensive form game can be constructed as follows:



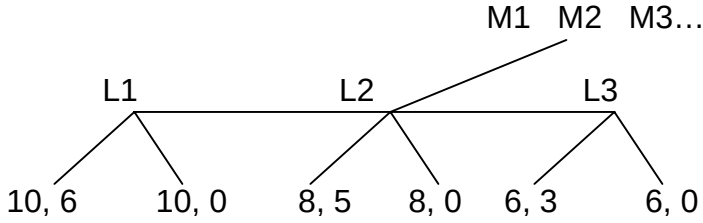
From the data presented above, it seems that the Philippine market went to (10, 6) situation. Very advantageous to the rich and middle class, but disadvantageous to both M1 and L2, and their employees.

The above is only for 2-players game form. But there are plenty of players or pharma companies in each drug

molecule category. So we can introduce multinationals 2, 3, (M2, M3) and so on. The same can be said of the local pharma companies, so there are players L2, L3, and so on.

Since there was no product withdrawal by the multinationals, then the right-hand side of the game form above did not happen. We can only extend the left-hand side of the game form.

Companies M1, M2 and M3 were all affected by the price control and their prices were halved from 20 to 10, from 16 to 8, and from 12 to 6, respectively. Companies L1, L2 and L3 subsequently made further cuts in their prices as a result of the significant price cut by the multinationals. The result may look like this:



The market was distributed to (10, 6), (8, 5) and (6, 3) situations but still, actual volume of drugs sold did not significantly increase, as shown by the above drug sales figures.

Did the poor benefit from such downward price spiral? A number of data say that the answer is NO. Because the poor think that P3 is still “unaffordable” for them since they may have to take the tablet 4x a day, or P12 a day.

For those with sentiments that the price control policy should cause pain and losses to the “profit-hungry capitalist multinationals”, the above exercise in game theory says there is a “law of unintended consequences” and that those

who were possibly hurt more, are local pharmaceutical players L1, L2, L3 and so on. Unless the said group of people also wanted to see local companies suffer pain and losses as the multinationals. In which case, their goal may be to see the collapse of capitalism in the pharmaceutical industry and government can begin taking over the industry in the form of drug nationalization.

If forcing and arm-twisting the multinational pharma companies to bring down their prices did not succeed in improving access of the poor to essential branded medicines, then the next option for the government maybe to purchase in bulk those medicines, the cheaper generics especially, and give away to poor patients for free. Some health professionals, pharmacists especially, would caution against giving away drugs for free if there is no professional supervision. Irrational drug use, if not more unhealthy lifestyle among the poor, will be encouraged by free medicines.

5. Politics and R&D don't mix well

High government political intervention creates uncertainty and disincentives for important research and development R&D for new and more disease-killer drugs. The R&D for HIV prevention is one example.

Table 1. Investment in R&D for HIV Prevention, $ million, 2008

	Vaccines	Microbicides	*% Dist'n.*
1. Public Sector	731	207	*84.4 %*
U.S.	620	154	
Europe	69	40	
Others	43	12	
2. Philantrophic Sector	104	35	*12.5 %*
3. Commercial Sector	33	3	*3.2 %*
Pharmaceutical companies	28	*	
Biotechnology companies	5	3	
Total global investment	868	244	*100.0 %*

* No investment reported

Source: Jeffrey Harris, "Why we don't have an HIV vaccine, and how we can develop one", Health Affairs, Nov./Dec. 2009, Vol. 28 No. 6.

The US government has been the main financier of R&D for HIV prevention

- 2004 and 2005, about 77 percent of total global investments (TGI)
- 2006 and 2007, about 68 percent, and
- 2008, 71 percent of TGI

Whereas commercial sector's investment was declining

- 2004 and 2005, about 8 percent of TGI
- 2006 and 2007, about 6 percent, and
- 2008, only 3 percent of TGI

* Same source above.

Dr. Harris noted that pharma and biotech companies have the expertise in vaccine development and commercialization. Almost all vaccines used globally today come from them. Yet, why is private sector R&D investment in anti-HIV small and now declining? 2 factors:

One, political risks. Like threats of compulsory licensing (CL). A successful HIV vaccine developer may be prevented from charging enough to recoup its investments. Plus governments' decisions to implement large-scale vaccination program is volatile

Two, scientific risks. All-or-none proposition from vaccine R&D. Manufacturers of unsuccessful vaccines failed to convert scientific gains into financial gains.

There are existing threats of CL and drug price control in Asia. In Thailand, CL for some anti-cancer and anti-HIV medicines and treatment have been declared. In Indonesia, there are proposals to mandate all multinational pharmas to put up local manufacturing plants. And in the Philippines, continuing price control policy.

6. On Creating Government Pharma Corporation

This subject keeps repeating in some quarters – that the Philippine government should create its own pharmaceutical manufacturing corporation, its own national drugs sales and marketing corporation, and related new enterprises.

One way to consider the merit or demerit of such proposal is to look at the food industry. There is no government restaurant, no government carinderia, no government supermarket, and yet people are eating. Compare that situation in the health sector. There are plenty of government hospitals and clinics, plenty of government drugstores, there is government health insurance corporation, there is

government price control and related regulations, and health problems are expanding. The main lesson here is clear: where there is bigger government involvement and intervention in sectors that are better left to private players in a competitive environment, endless problems result.

Consider also if there is a government carinderia corporation, government jeepney or tricycle corporation, government clothing corporation, and so on. The list of corruption and robbery scandals should be a lot worse, considering the existence of corruption scandals in almost all existing government corporations and financial institutions, due to the poor governance culture in the country.

7. Concluding Notes

RA 9502 or the CML has a provision to tweak with property rights, in particular the IPR through patent of innovator pharmaceutical companies, through the issuance of compulsory licensing (CL) and use of invention by government. So far these have not happened. The law is quite strict that there should be an existence of "national emergency or other circumstances of extreme urgency" before such provisions can be invoked.

In short, property rights by innovator companies have been respected so far. What the implementing agencies have focused their energy on is pricing left. That is, drug pricing has taken a more left-leaning policy of government price control. And it seems that the implementing agencies, the DOH in particular, are unfortunately stuck in a situation of continuing a policy that so far has not yielded results that will further justify the policy.

There are other policies though that the DOH and other government agencies, both national and local government units, can undertake that will really address the poor's deep

desire to have access to essential medicines and hence, will still advance the spirit and intent of CML. Like bulk purchasing of certain generic essential medicines and distributing them for free to the really poor patients.

Another important policy is to improve the business environment in healthcare, in order to attract more players and competitors. More competing drugstores, more competing hospitals and clinics, more competing health insurance firms, more competing pharmaceutical companies both local and multinational. It is not good to demonize certain players that are already here with confiscatory policies like price control. There are hundreds of potential players abroad that can come into the country to offer more competition to existing players. Then the Filipino people, the patients in particular, will have more options.

Finally, it is worth repeating this advocacy of Minimal Government Thinkers to different audience in different occasions: Healthcare is first and foremost personal and parental responsibility. Government responsibility in health care should be limited in a few important cases like conditions of health epidemics, taking care of those with physical and mental disability, and taking care of those really poor patients.

People should not over-drink, over-smoke, over-eat, over-sit, over-fight, then run to the government later to demand that “health is a right” after their internal organs have been dilapidated.

Personal and parental irresponsibility in healthcare, more than health epidemics and infectious diseases, is the no. 1 health risk around the world.

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Part 3
Short Articles and OpEds in 2010

1. Drug price control and health socialism

20 January 2010

While searching for materials on drug price control policy in google, I saw this entry in the LP website, "**Roxas: where's the second list?",** http://www.liberalparty.ph/news/News_LP%202009/second%20list.html.

The article was referring to the Senator's desire to see a second list or second round of drugs to be issued price control. The first list of drugs (21 molecules, nearly 100 drug preparations) was issued in late July 2009. Implementation of drug price control policy was August 15, 2009.

Drug price control, along with IPR-confiscation policies like compulsory licensing (CL), are examples of health socialism.

Price control policy says, "We don't care how excellent and revolutionary your products are. Their price should not be far from the price of the most mediocre products around. Their price should be socialized."

CL policy says, "We non-innovator companies declare upon you innovator companies: the high cost of your R&D and innovation, the losses in your failed researches and unsuccessful products marketed, are yours and yours alone. But your successful and highly saleable invention is also OUR invention."

It is dangerous to mix liberalism with socialism. Liberalism in its literal meaning, is to liberate, to free, to remove or limit coercion. Socialism in its literal meaning, is to socialize, to collectivize, by force and coercion.

It is unfortunate, therefore, that a key leader of a Liberal Party is advocating some populist and socialist policies.

2. Healthcare, rights and responsibilities

22 January 2010, www.thelobbyist.biz

The best form of healthcare is preventive, not curative. Among the preventive measures: people should not over-drink, over-smoke, over-eat, over-fight, over-sit in sedentary lifestyle. People should also clean their houses and surroundings and not live in dirty places. Taking vaccines is also one form of preventive healthcare.

Curative healthcare becomes important in cases of old age, accidents, pediatric diseases, not taking care of one's body, and so on. The best way to do it is through more choices for the public: more private health insurance, more private clinics and hospitals, more pharmaceutical companies, more drugstores, more physicians and health professions – in a competitive environment that compel all of them to improve their services and products continuously. In short, the best way to curative healthcare is through the market. Government role in healthcare should be limited to a few functions like in cases of disease outbreak, and patients with special health needs like those with physical and mental incapacity.

This is not the case in many parts of the world, unfortunately. The dominant thinking which is contained in various public policies, is that "health is a right." Thus, government should provide this service at a low cost or zero cost, to the public. And such policy should not make any distinction between people who got sick because they are old and weak, or have in-born physical or mental defect, and those who got sick because their internal organs were mutilated by over-smoking and over-drinking, or their heart and blood vessels were choked by heavy fat in their bodies. The government should provide healthcare for all. And since the government has no money of its own, the government should over-tax

the public, especially those who take care of their body well, are productive and are earning high.

That is not the only disadvantage of forced collectivized and socialized healthcare, or health socialism for short. The other disadvantage is that such policy can create “moral hazards” problem or complacency. For instance, instead of smoking one pack a day, two packs should be fine, since government will provide subsidized, if not free, treatment for all.

This is the main topic of a newly-released paper, “Health as a human right: the wrong prescription”, http://policynetwork.net/sites/default/files/righttohealth.pdf. The author is Jacob Mchangama, head of legal affairs of a free market think tank in Denmark, CEPOS. Mr. Mchangama wrote,

> “The right to health is highly problematic when construed as an enforceable right, with the state legally bound to enforce it in a particular and ideologically skewed manner. It would be better interpreted as a human aspiration whose implementation should be left to the democratic process and be decided upon the basis of the political convictions of the electorate.”

Meanwhile, on January 26-27 next week, there will be a big health forum, the 3rd MeTA Forum, sponsored by the Medicines Transparency Alliance (MeTA) Philippines, http://www.metaphilippines.org.ph/. The theme of the forum is “Medicines Transparency: a basic human rights issue.”

Among the topics to be explored are medicine procurement in the public sector, PhilHealth coverage for essential medicines, the current drug price control policy, and drugs bioequivalence.

I attended the 2nd MeTA Forum last year, and my brief account about the event is here, http://www.thelobbyist.biz/column_detail.php?id_article=1055&id_category=25

On a positive note, there was a good news early this week, “Filipino discovers new vaccine vs. malaria”, http://globalnation.inquirer.net/news/breakingnews/view/20100119-248174/Filipino-discovers-new-vaccine-vs-malaria

The Filipino scientist, Rhoel Dinglasan, is an entomologist and biologist from Johns Hopkins University in the US. Dr. Dinglasan’s invention will prevent mosquitoes from spreading malaria if they bite someone who’s been inoculated with the vaccine. The next questions after this great vaccine invention, are the following:

1. When will this be available for commercial production and distribution?

2. If this will be finally distributed, will the price be affordable and accessible, especially to the poor in poor countries?

3. If it is not deemed "affordable", will this new vaccine be slapped with government policies to make it "affordable", like compulsory licensing (CL) and price control?

While the vaccine is still undergoing further clinical trials and not available to the public yet, humanity will be stuck with old or existing vaccines and treatment against malaria, some of whom may not be very effective. Or the more effective ones are just waiting for some governments' intervention like CL and price control, which makes the inventors and manufacturers of those more effective drugs and vaccines, wary of bringing and selling those products to countries that are likely to be slapped with such government interventions like the Philippines.

3. Prevention vs. Medication

27 January 2010

The “3rd MeTA Forum” is on-going, January 26-27, at Diamond Hotel, Manila. It is sponsored by the MeTA Philippines. I attended day 1 yesterday, and the topics were some updates on what MeTA International and MeTA Philippines have achieved so far in making medicines become more accessible to the poor. Other topics were procurement of essential medicines by the public sector (DOH-affiliated hospitals, local government units), and financing of such medicines.

There is a long and expanded discussion on medicines, their high prices compared to some Asian countries, the shenanigans in public procurement of medicines, other curative aspects of healthcare. Buried or not even mentioned in the discussions, is the preventive aspect of healthcare.

When people live in dirty places, say under a bridge or a creek with stagnant water, or shrubby areas that attract mosquitoes and various insects, people there, especially children, will be susceptible to various types of diseases. Or when people don’t observe proper hygiene like washing their hands well before eating. Or when people over-drink, over-smoke, over-eat fatty food, and so on.

So when people become sickly, the eyes of the public and political leaders are on medicines and the pharmaceutical companies that produce medicines.

Anyway, this is a forum by an organization with explicit and categorical mission to make access to quality medicines be easier to the poor. So we stick to the subject. What I find rather strange, is the continued insistence that various government units, national and local, should be in the business of medicine procurement and distribution.

Last year in the 2nd MeTA Forum, there was a speaker from WB-Manila who documented instances of many drug warehouses by some big LGUs in the country – where rats, cockroaches, dust and garbage mix up in one room with useful drugs and expired drugs, and the room has no temperature control. In this case, even if we assume that there was no corruption and robbery in drug procurement, the big problem is the quality and efficacy of those medicines that LGUs distribute to the public.

Yesterday, there was a session where speakers noted that drug procurement prices by government units are several times higher than those in a number of Asian countries. Which point to either, (a) certain government personnel are bloating the procurement value so they can pocket and steal more money, or (b) pharma companies here, especially the multinationals, tend to price their products a lot higher in the Philippines than in other Asian countries. Or both happened.

If the main explanation is (a) above, then it's one clear case of government failure, happening persistently. Then there should be some persecution of guilty parties in order to send a strong signal to other government personnel that stealing is heavily penalized, not forgotten. Then corruption in public procurement will be drastically reduced, if not controlled.

If the main explanation is (b) above, then it's one clear case of the lack of competition among pharma companies, foreign and local. One policy implication is to encourage the entry of more players, both foreign and local, both manufacturers and traders.

Sadly, public policy actions in either (a) or (b) are not being done. Public procurement continues, foreign loans by the WB and other foreign aid institutions continue, poor health outcomes in the public continue, and endless taxation to pay the ever-rising public debts continue.

4. Uncontrolled passion for price control

30 January 2010, www.thelobbyist.biz

Price control is price dictatorship. Or one form of product coercion, or industry over-regulation.

There are many factors why the price of a particular commodity or service is deemed "expensive" and "inaccessible", especially to the poor. Foremost of which are (a) cost of production, including the cost of innovation and R&D, (b) cost of marketing and promotion, (c) cost of transportation, storage, distribution and retailing, (d) cost of taxes and regulatory fees by governments (national and local), (e) mark-up by producers and traders, depending on the extent of competition among suppliers and producers. Absence of any competition (monopoly) or just limited competition (oligopoly) means bigger mark-up.

Very often, government regulations directly or indirectly, determine the extent of competition or lack of it, in a particular industry or sector. Government franchising, for instance, creates monopolies. An electric cooperative, or a cable tv operator in a particular province or region, or tricycle route in a particular village or municipality, are given monopoly franchise by certain government agencies.

The drug price control policy is now five and a half (5 ½) months old since its implementation last August 15, 2009. There has been no serious study or assessment made by the implementing agency, the Department of Health (DOH) yet, on whether the policy has attained its primary objective – to make branded, popular and highly saleable medicines produced by multinational pharmaceutical companies, become more affordable and more accessible to the poor.

And yet, there are policy pronouncements by the DOH to issue another round of price control. Like this news report,

"**Therapeutic drug price cut considered**",
January 28, 2010,
http://www.bworldonline.com/main/content.php?id=5329.

A Singaporean physician has written a number of observations about this Philippine government policy. The latest of his discussion was "**The ultimate domino effect of ignorance**", January 28. 2010,
http://www.whitespacelab.com/2010/01/28/the-ultimate-chain-reaction-of-ignorance/.

On the proposed round 2 of drug price control by the DOH reported in the news story above, the occasion was during the 3rd Medicines Transparency Alliance (MeTA) Philippines Forum this week, January 26-27. I have attended the 2-days forum held at Diamond Hotel in Manila. Drug price control, aka maximum retail price (MRP), was extensively discussed in the morning session of day 2, last January 27. The five speakers in that panel were leaders from the Cancer Warriors Foundation (CWF), Health Action Information Network (HAIN), Philippine Chamber of Pharmaceutical Industry (PCPI, the alliance of local pharma companies), the European Commission Technical Assistance - Health Sector Policy Support Program (ECTA-HSPSP), and Philippine Health Insurance Corporation (PhilHealth).

Drug price control is explicitly supported by the CWF leader, was deemed "important but not enough" by the leaders of HAIN and ECTA, was shot down by the PCPI leader, while the PhilHealth official has some preliminary but incomplete assessment of the policy yet.

Succeeding discussions during the open forum showed that the price control policy rests on a hollow base. A speaker from a medium-size drugstore chain, for instance, said that contrary to expectations that the volume of branded medicines by multinational pharmaceutical companies that were hit by the policy will increase, the lady said that their

sales of such medicines even suffered a decline of 3 percent from mid-August 2009 to late January 2010. And why is this so?

It is because those who used to buy the affected drugs did not increase their purchase of said products. If they were taking one tablet per day, a 50 percent mandatory price cut did not cause them to buy two tablets per day. They just saved money. Meanwhile, the poor still found the 50 percent price cut not enough. Take amlodipine (most popular, branded drug is “Norvasc” made by Pfizer). Before the MRP, it was sold at Php44 per tablet. But the cheapest generic amlodipine, same dosage, was already selling at Php8 per tablet. So even at coercively reduced price of Php22 per tablet, it is still expensive for those who get another drug for the same disease at only Php8, or even Php11 per tablet.

In short, MRP benefited the rich and middle class, not the poor, who are the main target beneficiaries of the policy. Competition among pharma companies in the country made sure that poorer households and patients would have some alternative drugs at a lot cheaper price compared to branded and patented drugs. Besides, pharma industry leaders (both multinational and local) who spoke during the forum, pointed out that some small, local generic manufacturers whose drug prices are only about 70 percent lower than the branded products prior to MRP, suffered erosion of their market share as some of their customers shifted to the branded drugs that experienced mandatory price cut of 50 percent.

An official of another medium-size drugstore chain that I talked to said that their sales showed some increase in the volume of the branded drugs by multinational companies that were hit by MRP. Thus, local generic manufacturers were also badly hit by the policy. All drugstore managers (both chain stores and independent small ones) that I talked to during the forum said their sales as drugstores were badly hit too. Since they were advised by the DOH to keep their

percentage mark-up, say 10 percent, before and after the MRP, their profit was affected. At 10 percent mark-up, they make Php5.00 gross profit from a drug selling at P50. When that drug's price was forced by the government to be sold at only Php25, now they make only Php2.50 gross profit. And since drugstores are also forced by two laws to give mandatory 20 percent discount to (a) senior citizens and (b) persons with disabilities, the small mark-up they make from average customers can be wiped out by the mandatory 20 percent discount that the government mandated that drugstores alone should shoulder.

The uncontrolled passion for price control may be understandable if the intended target beneficiaries indeed benefit. But if it did not, such uncontrolled passion is no longer guided by the logic of economics and healthcare for the many. It is simply guided by politics and the deep desire for strong power to regulate other people's lives and business.

5. Cheap but not available

03 February 2010

During the 3rd MeTA Forum last week, presentation by Dr. Delen dela Paz of Health Action Information Network (HAIN, www.hain.org) and also a faculty member at the UP College of Medicine, she mentioned one result of the HAIN medicines survey in 2009: prices of essential generic drugs in public drugstores are about 1/3 than prices in private drugstores. So many poor people go to government-run or sponsored "botika". Problem is that availability of such cheap drugs was only 31% in public outlets vs. 61% availability in private drugstores.

One possibility here is that some private drug sellers do not go to the drug producers and wholesalers anymore, they buy from government drugstores at a low price, then sell these drugs somewhere at a higher price.

So, the hard lesson remains: cheap, yes, but less or not available publicly.

Which is better: more expensive but available vs. cheap but not available? If one is very sick, then price becomes a secondary issue compared to availability of a product that can make him/her well.

And this is one long-term effect of drug price control that advocates of the measure, especially those in the government, seem not to realize: more effective drugs, more disease-killer medications, will theoretically be sold "cheaper" in the Philippines. But their availability is small if not zero.

Manufacturers and sellers of those drugs will sell such products in Singapore or Hong Kong or Japan or other Asian countries which have no drug price control policy, and not

bring such products in countries where price control is being implemented, or pulled out but can be re-implemented anytime, depending not on any health emergency, but on certain political emergencies of the big politicians and the administration in power. So desperate patients will be forced to purchase such drugs abroad, at a more expensive price because of the cost of shipping and storage.

Also during the MeTA Forum, MeTA PHilippines leaders gave a press conference on day 2 (January 27). Dr. Alberto Romualdez, former DOH Secretary and currently MeTA Philippines chairman, said that "More than half of the country's annual expenditures for health products ranging from P100 billion to P150 billion are unnecessary because they hardly provide any therapeutic effect", see here, http://www.philstar.com/Article.aspx?articleId=544389.

This is related to "irrational drug use" issue. People are buying medicines and vitamins even with little or no proven therapeutic effect simply because such drugs are cheap, or are heavily advertised in broadcast media, in huge outdoor billboards, etc.

6. Health is a right, health is personal responsibility

19 February 2010,
http://peoplesbrigadanews.com/wpress/index.php

The concept of “Health is a basic human right” is popularly supported by many people. Both for its emotional appeal and for some international agreements, like the International Covenant on Economic, Social and Cultural Rights.

A sub-set or sub-topic then are the formulations, “Access to medicines is a basic right”, “Access to hospitals and healthcare is a basic right”, and so on.

Thus, others would extend them further and say, “Education is a basic human right”, “Decent housing is a basic human right”, “Cheap and abundant food is a basic human right”, and so on.

The term “right” implies and connotes entitlement. That is, regardless of the circumstances why one person or household or community has/have become sickly, they should be entitled to decent healthcare to be provided at a low cost if not free by the government, local or national.

This can be a big source of public debate between those who demand entitlement and those who question it. For the latter, for every “right” there is a concomitant “responsibility.” Thus, while people can demand that health care is their basic right, they are also expected to assume certain responsibilities about their bodies and their lifestyles

I personally believe that healthcare is first and foremost, a personal and parental responsibility. People should not over-drink, over-smoke, over-eat, over-fight, over-sit in sedentary lifestyle. People should not live in dirty places and should observe basic personal hygiene like washing hands carefully before eating.

Health inequity results not just because of income and social inequity, but also because of people's unequal inputs in taking care of their body. A person may be poor but if he does not over-drink and over-smoke and observe personal hygiene in his daily life, he will have a better health outcome than a rich person who over-drinks, over-smokes, over-eats and over-sits. The former, even without a private health insurance, all other things being equal, will less likely develop lifestyle-related diseases like hypertension, high cholesterol and obesity.

These topics are timely as the drug price control policy of the government is now more than six months old, and there is no formal assessment made by the Department of Health yet, on whether it has achieved its goal or not – to make essential but deemed expensive medicines become more affordable to the poor.

In the absence of such formal study and assessment by the DOH, some sectors and industry players – drugstore operators, pharma companies, some NGO leaders – have already produced their own findings: the answer is No. The policy, supposed to help the poor, did not benefit the poor.

The main reason is that there was a relatively healthy competition among pharma companies in the country already, among innovator companies and among generic producers. So while the rich and middle class were looking at a branded amlodipine, for instance, at P44 per tablet, there were cheap amlodipine generics already, sold as low as P8 per tablet. When price control was imposed, the P44 became P22. But the poor did not buy the P22 a tablet, because it is still high compared to what they are buying at P8 a tablet. So the poor did not benefit, the rich and middle class did.

Instead of forcing private companies to give the discounts, the government should force itself to procure essential medicines at no-corruption price and dispense these for free to the really poor, especially children of poor households who have been exposed to dirty environment for several years, who now have weaker lungs and other internal organs. This is where government can possibly put its limited resources – giving essential medicines for free to these patients.

The best form of healthcare is preventive, not curative. People should not abuse their body simply because alcohol, tobacco and fatty foods are more available and more affordable compared to several decades ago. But should they abuse their body, then they should suffer some consequences later.

Meanwhile, the damage to the country's investment environment as a result of no-time table drug price control policy should be big by now. Many revolutionary drugs, new disease-killer drugs that are available in other countries around the world, may no longer be introduced and sold in the Philippines. The most adversely affected then will be the poor and some middle class patients. The rich, the politicians and government administrators who pushed the price confiscation policy, will have the means and network to buy such drugs from abroad.

That is one example of the "law of unintended consequences."

7. Second round of politicized drug pricing

02 March 2010

Last Friday, February 26, this was the headline in the DOH website, **DOH announces second wave of drug price reduction** http://www.doh.gov.ph/node/2597.html.

Four days before that, February 22, there was a meeting by the DOH Advisory Council on Price Regulation, and one of the main topics that day was about the 2nd list of drugs where prices were voluntarily brought down by their manufacturers. I attended that meeting, that's why I knew about this. Here are a few points about the DOH announcement, above.

One, there is the impression that the foreign pharma manufacturers just brought down the prices of their products almost simultaneously. I gathered from some sources that the DOH leadership wrote to the officials of foreign pharma companies in the Philippines, asking for a new round of drug price cut. In short, there was a prior request from the DOH.

Two, one official of a big Filipino-owned pharma company noted that the DOH only wrote to the foreign manufacturers, but not to the local pharma companies. He said that the locals also have some capacity to bring down the prices of some of their medicines. So when the DOH advertise later those drugs and their new prices, only the foreign manufacturers that participated in that price cut will receive favorable feedback from the public.

There is no need for such DOH letter asking the foreign – or local – pharma companies for possible price discount if there is healthy competition among the players. No need for DOH press release on the subject, no need to deputize the Food and Drug Administration (FDA) so that drugstores will indeed implement another round of drug price cut.

8. CL and drug price control

20 April 2010

During the Coalition for Health Advocacy and Transparency (CHAT) forum last month assessing the cheaper medicines law (RA 9502), some friends and fellow NGO leaders argued that price control of off-patent drugs is not effective because there are competitor generics available already which are a lot cheaper even if innovator drugs' prices have been slashed to one-half. So they added that price control should be imposed on patented drugs, where there are no generic competitors yet, in order to force their prices down.

This logic is questionable. A friend and health NGO leader added with the following arguments.

"The multinational drug companies have always threatened a pull out of their products if they do not get what they want, but they have never really done it. In this case, with compulsory licensing or parallel import or government price control of drug prices, they can always threaten us again. They can again give the same threat but I doubt if they will really implement it because they will not take the risk of losing the huge amount of profit that they are amassing in the Philippines.

... the government should stand firm in its position of lowering drug prices. If the drug companies pull out, then we can do parallel importation. It is about time that we show these drug companies that we are not afraid of their threatened pull out. We should not be made hostage to their ploy.

Thus, patent protection for drugs should really be shortened so we are not dependent on these foreign companies for so long. We should develop our own drug industry as soon as

possible and encourage healthy competition among local drug manufacturers."

Yes, we all want cheaper medicines. My father is 82 years old and is practically dependent on medicines. My mother is 75 years old and is totally dependent on her weekly injection for her kidneys, for life! My wife has hypertension and is dependent on maintenance drugs. My daughter would need important vaccines, or would get sick from time to time.

I am lucky that I don't get sick, except on December or January where I get nasty cough because of the cold weather and holiday parties.

My parents are lucky to get 20% senior citizen discount on their drugs, but at xx thousand pesos per month of medication, it is still pocket-draining.

So competition among innovator and generic companies is really helpful. But government's continued taxation of medicines does not help. At 5% import tax + 12% VAT + regulatory fees (FDA, etc.) + local government taxes, they all contribute to expensive medicines.

Here are some of my rejoinders to my friend's points above.

If any of those multinationals will get out of the country, not just their products but their offices as well, then only traders and importers will bring in their products, new and old. The term for that is plain importation. The term "parallel importation" applies only if the (pharma) company has an office here, imports their patented drugs from their regional or global HQ at a high price. Then comes another company that will import the same patented drugs from other countries without the permission of the patent holder and sell at a lower price. That is why it is called "parallel" importation. In Filipino, "magkatabi" or "magkasabay na importasyon."

The best way that I can think of “developing our own drug industry" is to allow United Lab, Pascual Lab, other domestic pharma, to flourish and become multinationals themselves, exporting their drugs at least to other Asian countries. Let us not push the idea of the DOH or the Office of the President (OP) putting up a government pharma company like Thailand's Government Pharmaceutical Organization (GPO) as the fiscal cost of such project will be too high. If the DOH cannot operate a big government hospital with full efficiency, what makes us think that the DOH can operate a big pharma company efficiently?

I sincerely wish to see local pharma companies become multinationals themselves. SMC, Jollibbee, Figaro, Metrobank, SM, etc. are now big multinationals abroad. The cost of pharmaceutical R&D is so big, that only big companies will have the resources to do such job with full accountability. Meaning, if a local pharma company will sell its new line of innovator drug and some adverse results happen to patients and it gets sued, such local pharma company should have the resources to tackle both scientific and legal battles at the same time.

9. Health financing and market segmentation

20 April 2010

Market segmentation of healthcare financing via health maintenance organizations (HMOs) deregulation and more local government provision/participation will allow the poor to have greater access to better healthcare.

National health agencies like PhilHealth and the DOH should step back a bit, and allow more roles for local governments (like in San Isidro, Nueva Ecija province) and the HMOs. Let them be engaged in fierce competition to get more patients. When the national government comes in to provide health financing and insurance, there is zero competition. When the design of the project is lousy, its implementation will also be lousy. Wastes at the top are repeated at the bottom.

My hypothesis is that a better, wider coverage of health financing, can be done through more HMOs deregulation, more healthcare NGOs and more LGU participation, as add-on to PhilHealth membership.

PhilHealth is lousy. They say they have covered up to 85 percent of all Filipinos already. if that is true, why is it that in many hospital records, between 50-60 percent of costs come from out of pocket (OOP) spending, only 12 to 15 percent come from PhilHealth? And if PhilHealth is lousy after 15 yrs in existence, why should we call to further expand PhilHealth power and mandatory contribution?

Let us try other modes, like more HMOs competition, more cooperative and LGU health card system. If we combine competition among HMOs, cooperatives and LGUs, it should be challenging. Those who are lousy in providing health care will lose clients. But not PhilHealth, because membership there is by coercion. Whether you like it or nor, you become a PhilHealth member.

10. Medicinal elections

26 April 2010, www.thelobbyist.biz

Health financing and medicine prices are among the topics that would crop up during debates among opposing candidates and political parties as the national and local elections are just a few days away. Candidates tend to embrace the more interventionist, more confiscatory policies to become more popular with the voters. Among the populist promises made by national politicians are (a) extend and expand the drug price control policy, and (b) the state confiscating drug patents to further bring down prices.

Let us expand this into a hypothetical but probable scenario.

Let the Department of Health (DOH), upon the prodding of some influential legislators, extend drug price control, impose compulsory licensing (CL), and push parallel importation, to all patented drugs in the country. Do all three policies simultaneously, since these policies are now legal and allowed under the Cheaper Medicines Law (RA 9502) under certain conditions, and many people think that patented drugs = expensive = anti-poor.

With the high cost of inventing more powerful drugs, the innovator pharmaceutical companies will stop selling their newest drugs, their more disease-killer drugs into the country. They say,

"The most effective anti-hypertension drugs in the Philippines right now can bring down blood pressure in 1 hour or 30 minutes. Our new drug can do that job in 5 minutes, zero complication…. Or current anti-cancer drugs available in the Philippines can give an average patient some 20 to 30 percent survival chance. Our new anti-cancer drug can improve a patient's survival chance from 50 to 60 percent…. But you can not buy our drugs in any Philippine

drugstore. You have to buy them in Hong Kong or SingaporeJapan and other Asian countries with no price control, no CL." or

Is this a good and desirable situation?

Other people will say “Nothing to worry, multinationals have threatened in the past to pull out of the country, or pull out some of their products in Philippine markets if they will not get what they want. But they never did so since they still make lots of profit here. And patents have to be shortened as much as possible because 20 years patent is too long for profit-making. Patients over patents.”

This answer is not plausible for the following reasons.

One, there is no need to "pull out" newly patented, more expensive, but more disease-killer drugs from the country because the innovator companies, as mentioned above, will not make them available here in the first place. They will only bring in their off-patent, or patent expiring in 1 to 2 years, but not the newly-patented with 7 years or more patent life.

Two, the 20 years patent is only on paper. There are plenty of regulatory approvals AFTER a patent has been filed and approved, and regulatory scrutiny is increasing, not decreasing, around the world. Meaning, the patent starts from the discovery of the molecule, before undergoing various clinical trials, and not from the time the drug is marketed. Innovator companies say that of the 20 years patent life, the effective patent protection and “commercial or profit period” is only about 7 to 11 years because the first 9-13 yrs are spent on various clinical trials (from animals to people) and complying with various regulatory procedures by food and drugs administrations (FDAs) of governments.

Three, any adverse result to people that will occur during clinical trials which the innovator company cannot find a

solution, then that drug will be abandoned for commercial development, even if several million dollars have been spent already, even if that molecule has a patent already.

There are proposals also that the government should put up its own drug industry, similar to Thailand's Government Pharmaceutical Organization (GPO). The best way that I can think of developing "our own drug industry" is to allow United Lab, Pascual Lab, and other domestic pharma companies to flourish, via joint ventures with other big local Asian pharma companies (say from India, China and Pakistan) and become innovator multinational companies themselves, exporting their new drugs to other countries.

Let us not push the idea of the DOH putting up a government pharma company as the fiscal cost of such project will be too high. If the DOH cannot operate a big government hospital with full efficiency, what makes us think that the DOH can operate a big pharma company?

Many people never tire of citing "market failure" in health and other sectors. What they do not realize is the huge distortions created by bigger government intervention and taxation. At 5 percent import tax + 12 percent VAT + FDA regulatory fees + normal corporate taxes + local government taxes, government contribution to expensive medicines is often overlooked.

More competition, not more government regulation and taxation, will bring down medicine and healthcare costs over the long term.

11. Cancer and politics

13 June 2010, www.thelobbyist.biz

Cancer is among the top killer diseases in the world and in the Philippines. Personally, this disease is impossible to brush aside because a number of people close to me have died of it.

My elder brother, the eldest in our family, died of prostate cancer a few years ago. His wife and my sister in law, died of colon cancer several months before him. My mother's first cousin in Cebu also died of prostate cancer. One of our wedding godmother died of cancer early this year. Another godmother is undergoing chemotherapy with a rare type of cancer.

The latter is very close to us, especially to my wife. News of her having a cancer made us very sad. But news that she is fighting back and doing well also cheers us. Sometimes she is weakened and has to be hospitalized, on most days she is doing well and following the medications given by her physicians. Nonetheless, we only wish that the cancer cells in her body will be gone and defeated, we wish nothing less than that.

Thus, I really wish that this killer disease will be killed someday too, or be significantly neutralized and controlled. The role of innovator pharmaceutical companies is important here because they are the only ones – not the generic manufacturers, not the tobacco or alcohol or automobile or energy companies – which do serious and very costly research and development to find more powerful, more disease-killer drugs and vaccines.

While some cancer cases are due to genetics, many cancer cases are lifestyle related. Like lung cancer due to over-smoking and liver cancer due to over-drinking. Thus, the first

defense or “cure” against the latter type of cancer is to have healthy lifestyle. This highlights our main argument explained several times in this column, that health is first and foremost, personal and parental responsibility, not government responsibility.

Once cancer cells have grown, whether due to genetics or unhealthy lifestyle, the next line of defense will be by medications and physician intervention. It is important of course, to keep – or go back to – healthy lifestyle in order to help keep one’s body have stronger immune system.

When medications and medicines come in, that is where politics also come in. The immediate concern of many sectors in society, especially the health NGOs, patient groups, media, politicians and other political groups, is to pressure innovator pharmaceutical companies to significantly bring down the price of their new, more powerful, more disease-killer, but still patented drugs. The fact that all innovator companies are multinationals and are based in rich countries make them even more “devil-looking” in the eyes of such activist groups.

That there is huge cost in both actual R&D work and in complying with various requirements of various government drug regulatory agencies like the Food and Drug Administration (FDA) is less important to the different activist groups. The point is to use politics and political pressure to demonize the innovator companies. There are several tools to achieve this, like compulsory licensing (CL), parallel importation and drug price control. CL on some anti-AIDS and anti-cancer drugs has been used by the government of Thailand while the outgoing Philippine government has used drug price control for a number of drug molecules ranging from anti-hypertension, anti-cancer, anti-cholesterol, antibiotic, anti-diabetic and anti-thrombotic.

The high cost of new medicines is indeed a valid issue. This is no different from the higher prices of new models of mobile phones, flat tv, laptops and cars. New models are seen to be more revolutionary and contain qualities that are more powerful than the older models. But the availability of new and more powerful drugs and vaccines is sometimes a more basic issue than their price. There are many drugs that are deemed powerful but are not found in drugstores.

Desperate patients and their families and friends are willing to forego certain material things in their lives – like selling the second car, selling other properties – just to save a beloved person's life. For this type of people, the price of more powerful drugs is secondary to their availability. The typical argument is that they can earn money later on, but they cannot bring back to life once a beloved person and friend has died.

Politics should step back in areas where science and medicine have the dynamics and incentives to find treatment to killer diseases. Where there is profit to be earned in this sector, more pharmaceutical, biotechnology and research companies will sprout and compete with each other in developing more powerful drugs and treatment to cancer and other killer diseases. The public's desire for more powerful but more affordable drugs will be assured by a healthy competition among innovator and research companies. Once the patent has expired, the next line of competitors, the generic manufacturers, will further introduce off-patent drugs at a lot lower price.

The important thing is that new, innovator drugs from innovator companies should be allowed and encouraged to come on stream regularly. Patients' lives are more important than politics.

12. Health insurance monopoly

22 June 2010, http://peoplesbrigadanews.com/wpress/index.php

To get sick is among the most difficult things to happen in a family. Depending on the seriousness of the disease, a household which has no health insurance coverage for family members will encounter mental and financial anguish. This is why having a health insurance is an important consideration for many households.

There is an interesting news report in the New York Times this week, about **A Dirt-Poor Nation, With a Health Plan**, http://www.nytimes.com/2010/06/15/health/policy/15rwanda.html?hpw.

It is about the case of Rwanda, a very poor nation of 10 million people in Central Africa. People pay an equivalent of $2 per person per year health insurance premium, and 92 percent of the population is covered. It is a "no frills" health insurance system by the government that covers the basic diseases by ordinary patients, like diarrhea, pneumonia, malaria, malnutrition and infected cuts. The article added,

"Local health centers usually have all the medicines on the World Health Organization's list of essential drugs (nearly all are generic copies of name-brand drugs) and have laboratories that can do routine blood and urine analyses, along with tuberculosis and malaria tests."

The $2/person/year is definitely not enough. Two foreign aid programs, the Partners in Health (a health charity based in Boston), and The Global Fund, provide the bulk of health subsidies. The former said its own costs ran $28 per person per year in areas it serves, and it estimated that the government's no-frills care costs $10 to $20.

The problem with this scheme, however, is that price differentiation and market segmentation is not practiced. A

millionaire and a jobless man both pay only $2/person/year. Such ridiculous pricing is one reason why government should step back a bit in healthcare.

Those who are rich should be encouraged to get out of socialized healthcare system by allowing a healthy competition among private and cooperative health medical organizations. Since there is a long line for patients going to government health centers, the rich will voluntarily opt out and go to their private health insurance for quick treatment.

The really poor should get the bulk of subsidy. And those who are irresponsible about their body should get a second and supplementary private health insurance. The huge cost of treating someone with lung cancer due to over-smoking, or someone with liver cancer due to over-drinking, or someone with diabetes or hypertension due to over-eating fatty foods should not be borne by everyone. Let those patients, their families and friends, pay for the extra costs of not taking care of one's body.

This is one way of making people be more conscious and be more responsible about their body. And this is one way of reducing corruption in government too, as there will be less tax money that will be available for some arbitrary spending. Health insurance should not be a monopoly of government. For countries with weak promulgation of the rule of law, where there is monopoly, there is huge waste and robbery.

The incoming administration should prioritize deregulating the private and cooperative health insurance sector. Where there are plenty of competitors, each player will be forced to provide better quality services at lower or competitive cost to the public. Of course, there will be opportunist and unethical providers among those competitors. And this is where the government can come in: to enforce the rule of law, that private players should provide services to the public without compromising on quality and safety of the patients.

13. Fat accumulation and capitalist accumulation

04 August

Obesity is one indicator of affluence in society. When economic productions are efficient and modern, there is ample production of many things -- food, beer, appliances, cars, cellphones, and so on. When food is plentiful, its relative price is low or cheap, so people eat and eat a lot. When car manufacturing is efficient, thousands of cars are churned out every month and cars are sold rather cheaply, well at least compared to several decades ago. And people tend to ride their cars even for short distances, they do not walk or ride bicycles anymore. And with fast production of tv sets, tv programs and movies, many people become couch potatoes, they sit down for hours watching tv or movies.

The overall result in economic affluence plus personal -- and possibly parental -- irresponsibility, is that people will have ugly bodies, like being over-fat or obese. If they eat like a pig and they do not burn enough energy, most likely they will have a body like a pig. They become obese. Of course there are also biological and medical reasons like low food metabolism, but the dominant explanation for high incidence of obesity is lifestyle changes and the success of economic modernization and capitalist accumulation.

In the US, about 26.7 percent of the entire population, around 73 million people, are considered obese. And this figure is considered as understated as the method in producing the figures is via phone call interviews, where some people would tend to understate the extent of fat accumulation of their body.

See one news report here, **Obesity rates keep rising, troubling health officials**, http://http//www.nytimes.com/2010/08/04/health/nutrition/04fat.html?_r=1&hpw

The Center for Disease Control and Prevention estimates that the medical costs of obesity in the US is around $147 billion a year.

But is it government responsibility when people do not take care of their body? If people would love to eat and eat without control, or become too lazy to walk even for short distances, or be in love too much with their sofa and tv set that they sit there for many hours everyday, is it then government responsibility to treat them when they become obese?

A corollary to this is when people would drink and drink, smoke and smoke, almost without control, and develop various diseases in their internal organs later. In a social philosophy of "healthcare is a right", the State will create a complicated system of social engineering where those who work hard and take care of their body more responsibly will be forced by the State to contribute to a massive healthcare budget, in order to subsidize the health needs of those who are less responsible about their own body.

While capitalist accumulation in the social and economic sphere has been generally successful, the State's social engineering scheme of over-taxing the hard-working guys and more efficient business enterprises can be wasteful.

Accumulating fat in the body is personal choice. Using the savings of other people to correct such self-inflected disease is not a wise move.

14. Medicines, innovation and pricing

13 August 2010

It is good to find a physician with a good grasp of economics and finance, and thus can write well on health policy issues. One such physician that I have read is Dr. Tej Deol of Asia Health Space blog.

In his recent long article, **Little red riding hood (society) and the big bad wolf (branded pharma)**, http://www.asiahealthspace.com/2010/08/03/little-red-riding-hood-society-and-the-big-bad-wolf-branded-pharma/, Dr. Tej discusses about certain expectations that pharma companies should sacrifice something for society. It is a philosophical-economics-innovation paper, well-written.

The author wrote for instance, about the role of pricing when a pharma company discovers a drug that is so valuable and innovative.

> "In well-functioning competitive markets, industries don't have to defend their pricing choices to anyone in society (except its shareholders!). If a particular company prices its product (i.e a new patent protected antibiotic for urinary tract infections) too high, consumers (patients) will substitute to cheaper alternatives. For the vast majority of common illnesses there are plenty of cheap and effective treatment doctors and their patients can choose from. Patent protection to encourage the investment in new technologies/drugs is helpful in justifying the investment but it does not create a monopoly nor eliminate competition. Thus, pharma companies must expend "more on marketing than on R&D ". In order to achieve an acceptable market penetration to justify investment you must market your products. If the condition is rare, and your product is truly innovative

> and value enhancing, then high prices are very justified and less can be spent on marketing until someone else can challenge your product with a cheaper but equally effective alternative."

Several important concepts were touched by the above paragraph:

a) Pricing of products and to whom it should please,
b) Competition and substitution of products,
c) Patent and protection of a new invention,
d) Role of marketing for drugs on common diseases,
e) Pricing high for revolutionary drugs for rare conditions.

People wish to get something very useful and revolutionary, something that is not available yet and wish were to be created by some magicians or angels. When that "something" was finally invented by humans and made available to the public but was unfortunately priced high, people would tend to demonize those inventors.

This is understandable somehow, part of "human nature" to wish to have something impossible be made possible. Like being made available to them for free or at a very low price. But inventions and discoveries, by nature, are scarce and limited. The scarcity (if not non-availability) of something -- like oxygen under the sea, or diamond or a super-fast car -- can be reflected by its price. The higher the price, the more scarce that product or service is. The lower the price, the more abundant a commodity is. Air is free and we pay nothing to breathe the air because its supply around us is unlimited.

Dr. Tej concluded his paper with the following observation:

> Anyway, in my humble opinion both Little red riding hood and the big bad wolf are getting screwed. "Society" loses out on an critical source of healthcare

> innovation and forces large deep-pocketed branded pharma firms into consolidating with generics manufacturers with everyone competing on price and nobody competing on quality. Worse yet, once the consolidation matures, the prices will rise anyway. So in the end, no specialty pharma companies; no pure generics manufacturers; only consolidated hybrids and a commoditized industry with limited incentive to compete on quality or price.

It is important that people and their private enterprises would stick to certain division of labor. There are those who love high risks-high returns, long gestation and lots of hard R&D work; and there are those who love low risks, low (but assured) returns and little or no discovery and innovation work. Then people and their private enterprises can compete with each other in both product quality and product price.

The spirit of competition should be retained at all times at all places. When people feel there is too much competition on existing products, technologies and/or processes, then this will encourage, if not compel, them to do innovation work.

People are getting more demanding in healthcare. If they get sick, they want to get well within 1 or 2 days, not 1 or 2 weeks or longer. Hence, they demand more powerful, more revolutionary drugs and treatment. Health collectivism and coercion though would force pharma companies and retailers to focus on low price. If the price is deemed “expensive” even if the drugs are indeed highly effective and powerful, governments come in to impose price control and similar schemes. And this is where health danger and economic uncertainties would flourish.

15. Drug price control: 1 year of failure

19 August 2010
http://peoplesbrigadanews.com/wpress/index.php

Last August 15, the drug price control policy turned exactly one year old. The government, through the Department of Health (DOH), imposed a 50 percent mandatory price reduction for many branded drugs that it deemed were essential but expensive. Let us see some results of the policy.

Medium-sized chain MedExpress and Manson drugstores reported some chilling sales data. From August-December 2009, all the price-controlled drugs suffered a 3.4 percent decline in volume and 34.3 percent decline in sales value, compared to August-December 2009. Comparing January-May 2010 with January-May 2009, sales volume of the price-controlled drugs has managed to post an average of 7.3 percent, but sales value has declined by an average of 65.4 percent.

The sales value decline is bigger than the 50 percent forcible price reduction because there are other mandatory discounts that the government has imposed on drugstores on top of the 50 percent mandatory price cut, like 20 percent mandatory discount for both senior citizens and persons with disabilities (PWDs).

There are a number of reasons why the drug price policy failed. Four reasons stand out.

One, the policy was driven mainly by politics and not by any national health emergency. A former Senator running for President but lagging in Presidential surveys pushed hard the issue some 12 to 13 months before the May 2010 elections. A very unpopular President serving the last of her

9 years in office rode on the emotional popularity of the measure.

Two, competition among innovator drugs and generic drugs was already dynamic prior to the price control measure. Take amlodipine molecule for anti-hypertension. The most popular drug was Norvasc 5mg, selling for P44 a tablet. Then it became P22. But the cheapest generic available prior to price control was selling for only P8. The poor who buys the latter drug finds the P22 still a lot more expensive and hence, will not buy it.

Three, the policy has the unintended consequence of hitting the local pharmaceutical companies that produce the competing generic drugs. They were pushed to further bring down their already low prices.

Four, some small and independent drugstores were forced to further cut their personnel and other cost of operations just to survive, or close shop altogether. Which contributed to more unemployment in the country.

It is important that the government should focus on encouraging competition among various drug manufacturers, among importers, drugstores and hospitals. The new President should signify that the government will not entertain another round of drug price control in the next six years of its term. This will help improve the investment environment in a country that badly needs more investors and job creators.

16. Drug price control a year after

19 August 2010
www.manilatimes.net/index.php/opinion/24031-drug-price-control-a-year-after-

The drug price control or price regulation policy will turn exactly 1-year-old on August 15, 2010. A year after its implementation began, has the policy achieved its goal of making essential, popular and branded drugs become more accessible to the poor? To help us answer this question, let us see some sales data from two drugstore chains, MedExpress/Manson drugstores and Watsons, which, starting this year, has become the second biggest drugstore chain in the country. The officials of these stores gave me permission to use their data for this article.

MedExpress' sales data for the price-controlled drugs showed the following: From August to December 2009 vs. same months in 2008, sales volume fell by 3.4 percent and sales value tumbled 34.3 percent.

From January to May 2010 vs. same months in 2009, sales volume has managed a 7.3-percent increase but the value plummeted by 65.4 percent, whacking the retailers' margins.

The sales value decline is now bigger than the mandatory 50-percent price reduction because there are additional government-imposed discounts, such as the mandatory 20-percent off for senior citizens and people with disabilities (PWDs).

Data from Watsons show that from mid-August to December 2009 compared to same months of 2008, sales volume of all price-controlled drugs increased by 35.9 percent although sales value declined by 13.2 percent. And from January to April 2010 vs. January to April 2009, sales volume has

increased even higher to 57.2 percent while the peso revenue was flat at 0.2-percent growth.

What are the implications of these numbers?

At first glance, one may conclude that price control was a success in making more popular, previously expensive drugs by multinational pharma companies become more affordable to the poor. Wrong.

Watsons drugstores are located mainly in the malls, especially in SM malls, which the richer ABC income class of people frequent. A 50-percent forced reduction in prices by some of the most popular, branded drugs by multinationals prompted the ABC class to patronize these products and abandoned some of the generics drugs that they used to patronize.

This result is a clear setback to the government's 22-years old campaign to promote generics through the Generics Law of 1988.

Did the government, the DOH officials in particular, foresee this huge and glaring contradiction between its old policy of generics promotion and its new branded drugs promotion?

What about the poorer consumers and patients, those who are in the rural areas and do not frequent the malls, did they also join the bandwagon shift to the branded drugs?

Judging from MedExpress' sales data, the answer seem to be No. The 7.3-percent modest growth in sales volume in the first five months of 2010 can be attributed to the shift by some of MedExpress' wealthier consumers in the provinces to the branded drugs. If the poor also joined the bandwagon, then the increase in sales volume would have been larger than 7.3 percent.

Prior to the imposition of price control policy last year, there was already a healthy competition among many pharma companies, especially between the innovators and generics manufacturers. One clear example is amlodipine molecule used to treat hypertension. The cheapest generic available on the market prior to price control was selling for only P8. The most popular brand name version was Pfizer's Norvasc, selling for P44 a 5mg tablet. After the mandatory 50-percent discount, it became P22.

For the poor who used to patronize the P8 generics, the P22 Norvasc was still expensive and thus, a shift to the branded drugs is still not viable.

Meanwhile, a number of small and independent drugstores, those which do not belong to any drugstore chains, have been forced to drastically shrink their operating costs including laying off some staff. Some also have had to stop selling some of the price-controlled drugs altogether as they encountered problems in getting rebates from the manufacturers, and they could no longer make useful profits. The situation of "cheap but not available" drugs in some rural areas has become more pronounced.

If the policy is a failure, then the DOH should consider advising the new President to recall or abrogate Executive Order 821 issued by the past President imposing price control on certain drugs.

It is time to move on, abandon politicized pricing of certain drugs, and focus our energy on the bigger issue of healthcare coverage for many Filipinos.

17. Drug promotions and government

02 September 2010

The Medicines Transparency Alliance (MeTA) - Philippines conducted a series of workshops for various groups and sectors on "Ethical Drugs Promotion and Marketing", August 31 to September 3, at the Asian Institute of Management (AIM) in Makati. The workshop for civil society groups and consumers was held yesterday,, September 1. Leaders of member-NGOs of the Coalition for Health Advocacy and Transparency (CHAT) like me attended the workshop.

The main resource speaker for all the workshop groups was Ms. Carole Piriou of Health Action International (HAI), a think tank based in Amsterdam. Carole gave a good presentation but I did not agree with some of her analysis and recommendations.

Based on some HAI surveys or studies, they say that "newer medicines are not necessarily better" as 69 percent of new (and patented) drugs are "nothing new." This assertion should get the attention and counter-arguments of the innovator pharma companies because the purpose of medicine innovation is to develop more disease-killer drugs, or retain the original disease-killing capacity but with the minimum adverse effects. That should be "something new."

Another issue that Carole discussed, was that Continuing Medical Education (CME) via sponsored symposia and conferences by pharma companies for physicians have direct and positive correlations to increased prescription of the drugs produced by the sponsoring company. I think this point is not surprising. I do not know if there is a neutral or independent body or organization that provides CME to physicians where all new drugs and vaccines from different innovator and generic pharma companies are presented and

discussed in terms of their disease-killing capacity, any adverse effects, price, and so on.

In the absence of such independent group, then drug manufacturers will launch their own CME to certain physicians to explain about the properties of their new drugs. This has the indirect effect of active promotion and marketing, of course. If the manufacturers themselves will not do it and there is no independent body that will study and analyze the properties of new drugs coming out from different pharma companies, who will?

Dr. Kenneth Hartigan-Go, a former official of MeTA Philippines, now a professor of health management at the AIM, also gave a short presentation of the kind of promotions and marketing that some pharma companies advertise in media -- radio, tv, newspaper, and so on. The pictures that he showed were indeed very revealing.

An important consideration why many pharma companies resort to aggressive advertising and marketing, is because majority of Filipinos do not have outpatient health insurance card. PhilHealth can be used only if one is confined for at least 24 hours. So since people do not have outpatient health cards, they do not see a doctor for their minor diseases and get professional advice. They resort to self-medication, get the drugs that they heard on tv, radio, etc.

The biggest pharma company in the country is United Laboratories or Unilab. Its gross sales in April 2009 for instance, P25.8 billion, was slightly bigger than the combined sales of no. 2 (GSK), no. 3 (Pfizer) and no. 4 (Wyeth). Unilab is also the biggest drug advertiser in the country, Its ads are visible in radio, tv, newspaper, billboards, and so on.

So, should government further regulate drug promotions to physicians and the public? My quick answer is No. When there is sufficient competition among various pharma

manufacturers, among drugstores and among healthcare providers, that competition is the best regulator in terms of price, product quality, and corporate accountability.

Besides, the Food and Drug Administration (FDA, previously BFAD) has its staff over-burdened already with regulating everything from new (and/or imported) drugs to skin whiteners to fruit juices to processed/manufactured foods, drinks and soda, and so on. So to ask them to create a new set of regulations and monitoring system will simply raise public expectation and later, public disappointment.

Civil society – NGOs, media, consumer groups, church groups, etc. – bonding into a big coalition can monitor drugs promotion and marketing. Then slam-dunk those firms that exaggerate the properties and healing power of their drugs. This public pressure and consumer vigilance is a more effective regulator than any combined government bureaucracies' regulation.

Comments to the article:

Hi Nonoy! While I agree that NGOs and the public can serve to regulate drug promotions, the fact remains that we still NEED to educate the public on what exactly drugs/medicines are, may it be OTC OR ETHICAL drugs. Until clear understanding on the nature of drugs and medicines happen, regulation on promoting them must be done. There are a lot of misinformation we see now in the many drug advertisements that mislead the public resulting to DRUG MISUSE. Result, disease complications happen unnecessarily. -- Leony

Thanks Leony. I was also told by one pharmacist that giving away drugs for free by government or other sectors, if not done with supervision by a trained health professional like a pharmacist, will only result in irrational drug use and hence, might create more heatlh problems later on. – Nonoy

18. Centralized healthcare and malnutrition

05 September 2010

For many of us in developing countries, it is unthinkable that public healthcare in rich countries can result in more malnutrition among the patients, especially the senior citizens.

But a WSJ article, **Postcard from the NHS** http://online.wsj.com/article/SB10001424052748703467004575463772676581084.html reported the following to be happening in UK hospitals:

> In 2007, 239 patients died of malnutrition in British hospitals, the latest year for which figures are available. A wag might say it must be the English cuisine. But the real roots of this tragedy lie in Britain's government-run medical system....
>
> A British charity, Age U.K.... reports that in 2007-2008 148,946 Britons entered hospitals suffering from malnutrition and 157,175 left in that state, meaning that hospitals released 8,229 people worse-off nutritionally than when they entered. In 2008-2009, that figure was up to 10,443.
>
> The problem is not a lack of food. Hospital malnutrition mostly affects the elderly or otherwise frail, who often need individualized mealtime assistance. Spoon-feeding the elderly may not seem like the best use of a nurse's time, but for some it may literally be a matter of life and death. Yet the constant scarcities created by government medicine, along with the never-ending drive to trim costs, has led the National Health Service to give nurses additional responsibilities and powers in recent years. Inevitably, this leaves them with less time to make sure patients are getting fed.

I have read a few months ago the plan of the NHS to decentralize healthcare provision in UK. That is, move a number of healthcare functions from the central government to local government units.

While decentralization is generally better than centralization in healthcare provision and other social services, this move still does not get away from "more government role and responsibility" in healthcare, instead of moving a number of responsibilities to personal and corporate responsibilities via private healthcare insurance firms that compete with each other.

The government will not confiscate too much money from the people in the form of high taxes, the people keep more of their income and savings, they get their own private health insurance. If they are not satisfied with their current provider, or someone else will offer a better healthcare package, people can buy a new health insurance there.

This competitive system of health provision will do away with less sensitive or lazy health professionals, do away with inefficient healthcare management system.

People from developing countries should watch such development in the healthcare system in many rich countries. The "free healthcare" system there is not mostly a "bed of roses."

19. New vaccines, via competition or more regulations?

07 September 2010

A World Health Organization (WHO) official said in an influenza conference in Hong Kong, as reported in yahoo news, that **WHO wants faster, more flu vaccine production**, http://news.yahoo.com/s/ap/20100906/ap_on_he_me/as_med_hong_kong_flu_vaccine.

The world ducked the most recent outbreak, swine flu or H1N1 virus, that last year was feared by WHO and officials of many government health agencies, to possibly cause "millions" in death. The virus killed an estimated 18,600 people worldwide, still a big number.

The WHO wants anti-outbreak vaccines to be developed quick to save more lives. It is a noble goal and many people, me included, would support it. The world has seen "bird flu", SARS ("civet flu"?), swine flu, other variants of ordinary flu. I think it will not be far out for the world to see new viruses someday that can be called "horse flu", "sheep flu", "cat flu", "dog flu", "elephant flu", "tilapia flu", and so on.

I also think that some big pharma companies are already doing serious research on projecting evolving and mutating diseases from current ones where effective treatments are already available. So that when new flu, virus and diseases will show up someday on a global outbreak trend, those companies will need only short notice of several weeks to come up with an effective vaccine to kill such new diseases.

Competition among innovator pharma companies should expand the range of choices by the people and public health agencies by various governments. Those companies are driven by profit and by fear of being bankrupt. Since medicine innovation is a high risk, high returns or high losses

activity, the probability of going red someday is always a possibility. Generics manufacturers do not face this kind of high risk, high returns situation. They do not have to reinvent the wheel as the most successful molecules to treat particular diseases have already been discovered by the innovator companies.

But does the WHO favor more competition and innovation always? I remember that sometime in 2008, the WHO was busy discussing how to kill, or shorten, or confiscate patents of certain newly-discovered medicines and molecules. This was through its lesser-known body, the Inter-Governmental Working Group (IGWG) on Innovation, Intellectual Property and Health.

The WHO as a leading international body and bureaucracy on public health cannot hope to see more powerful vaccines someday if its other agenda is to restrict and penalize those who invent new drugs and new vaccines. The organization seems to be promoting more health populism and socialism rather than more competition and more realistic defeat of existing and emerging diseases.

20. Info asymmetry in healthcare

08 September 2010

After posing "Centralized healthcare and malnutrition", an economist friend commented,

> *I do agree that the "free" health care system is not a bed of roses. However, so does unregulated private sector provision. I think a more relevant policy is that patients should know their options. They should know how providers fare in quality of care measures. Whether they be public or private providers.*

Good points there. I believe in the power of market segmentation -- different services for different people/consumers with different needs and different budget. Consider the food sector: there is no government carinderia or government restaurant or government supermarket, and people are eating. The rich may eat at P2,000/meal, the middle class may eat at P200/...meal, the poor may eat at P20/meal. But it does not mean that the P20/meal, only 1% the cost of what the rich may eat, is poisonous or non-nutritious. It can be a complete meal already (carbo, protein, vitamins, etc.) depending on how the household would prepare and cook the food. There is govt. presence in food, like the National Food Authority (NFA), and all it does is accumulate debt year after year, that we taxpayers have to shell out year after year too.

Compare that in healthcare: there are thousands of government rural health clinics, thousands of govt. "botika ng barangay", dozens of govt. hospitals, there is a govt. health insurance corp, a govt. drug price control policy, etc. and health problems are expanding.

When you deregulate markets, like food, clothing, footwear, etc., there is a market for everyone, rich and poor, young and old.

My friend replied back:

> Clothing, food, and footwear are pure private goods. I am for private sector involvement but more importantly, I would rather have people informed of the quality of service they are about to take. One important ingredient for free markets or deregulation to work is absence of, or minimal information asymmetry, people are informed. More tuned to competition, minimization of information asymmetry.

Information asymmetry is a problem or a situation where one party (say the healthcare provider (like the physician) is more knowledgeable than the other (say the patients), and this results in inefficiency of resource allocation in society. Like the less-informed party will pay more than what he/she is supposed to pay if he/she has more information.

One solution to this problem is to encourage branding. Makati Medical Center (MMC) brand. St. Luke's Medical Center brand. Medical City brand, Maxicare brand, Intellicare brand, etc. People will associate the "St Luke's brand" as expensive, great healthcare, etc. versus another hospital's brand or image, and another HMO's brand.

Like in food sector, again. When it's Jollibee or Mcdo or Chowking, people don't care whether the branch is in Davao or Cubao or Tuguegarao. They assume that the food quality, food price, service, etc. is the same for all branches. People are buying the brand and all products and services that go with that brand. Information asymmetry is drasticaly reduced if not removed.

21. Free market and better health

22 September 2010, www.thelobbyist.biz

Free market means free individuals. Markets are composed of individuals – sellers and buyers, producers and consumers, rich and poor, young and old, foreigners and locals. When individuals are free to produce and/or sell something with the minimum or zero institutional restrictions like high government taxes and bureaucracies, they become more productive and soon, they become wealthier.

When people have more economic resources, they can buy more food, more healthcare, more spacious house, better education. The end result is healthier people in general.

This is the main message of the paper, “Free Trade for Better Health” by Philip Stevens. The paper is one of the 11 chapters in a book, **Towards a Healthy Future? Indian and Global Experiences** published last year by Bookwell and Liberty Institute, both based in New Delhi, India.

Philip’s article discussed the following: (a) the role of economic growth in improving health outcomes of the people, (b) the role of free trade in economic growth, and (c) the role of international trade in health promotion across countries and continents. One graph that was shown is about life expectancy and income: the higher the income, the longer the life expectancy.

There is one table that summarizes the Modes of trade and the corresponding Health services.

1. Cross border trade --> telemedicine service.
2. Consumption abroad --> medical tourism, or patients seeking treatment abroad.
3. Commercial presence --> foreign commercial presence in the hospital or insurance sectors, and

4. Presence of natural persons --> movement of health professionals to provide services abroad, like the Filipino nurses and doctors who work abroad.

Telemedicine is a fantastic development. Decreasing costs of communication allow doctors to examine x-rays or even perform telesurgery on a patient in another country. Health professionals in rural areas can consult specialists in urban centers, reducing the need for costly referrals.

Medical tourism is another fascinating development. The Philippines can retain its highly skilled physicians, nurses, therapists and other health professionals, create allied jobs through modern hospitals and clinics that attract thousands of patients from abroad seeking special medical treatment and/or cosmetic surgery.

Commercial presence is allowing foreign hospitals, clinics, health insurance companies, to bring in capital, new medical technologies and processes, into another country. The Philippines is slow or not adopting this yet due to certain constitutional restrictions on foreign investments and the practice of health professions by foreigners in the country.

Movement of Filipino health professionals abroad to render their services there is often seen as “negative” because of the perceived brain drain problem. This is a wrong attitude for at least two reasons. ***One***, there is limited economic and professional development in the country due to certain restrictions made by the Constitution, certain laws and government bureaucracies. And ***two***, many doctors and nurses who work abroad come home after several years as health entrepreneurs who put up new clinics or hospitals or health insurance firms. They bring home their savings, the new technologies and processes they learned abroad.

Forcing health “equality” via numerous restrictions and taxation in global trade and movement of people tend to boomerang in the form of slower economic growth and poorer health.

22. Philhealth bureaucracy

(This is merged and slightly revised version of my two blog articles, “Expand PhilHealth coverage?” last September 24, 2010, and “PhilHealth bureaucracy” last October 13, 2010)

A friend noted in his facebook blog about the Philippine Health Insurance Corp. or PhilHealth:

> *According to the National Demographic and Health Survey (2007) only 53% of Filipinos have coverage under PhilHealth or the National Health Insurance Program (NIHP). IPD research shows that of these, only half are able to use their PhilHealth card and get the benefits. Only 34% of their hospitalization expenses are being covered by PhilHealth. Therefore, only 7.7% of hospitalization/medical expenses of Filipinos is being covered by PhilHealth.*
>
> *...PhilHealth does not yet cover mid-way care for chronic diseases and other illnesses that are potentially fatal without mid-way care, such as hypertension, diabetes, HIV, colon cancer, asthma, and stroke. PhilHealth benefits package should cover these. Maintenance drugs for hypertension, monitoring for diabetes, anti-retroviral drugs for HIV, and physical therapy for stroke victims should also be included. Home visits for the aged, pregnants for pre- and neonatal care and birth planning, and undernourished children are among the items that should further be included under a more inclusive health insurance program for all Filipinos.*

Yes, right now, PhilHealth does not cover (a) outpatient services, (b) dental services, (c) annual check-up, what else. Philhealth is very strict in collecting contributions, one should have paid at least 9 months straight, etc. before one can possibly file for any claims. But when one claims for

reimbursement, he will wait for at least 60 working days, or almost 3 months including weekends and holidays, even if the proposed claim is as low as P1,000.

My physician friend says that he gets paid about 4 months delayed. The hospital where he works may be filing their fees rather late, but the bulk of the delay lies on PhilHealth. He also observed that during election period, physicians are paid even much later.

Doctor Alberto Romualdez, former DOH Secretary, observed that of the top 10 hospitals in terms of volume of claims from PhilHealth, 9 are private hospitals, only 1 is government hospital. One way to look at this is that PhilHealth in effect is paying more to the rich and middle class patients, not to the poor.

Well, government hospitals do not provide drugs. Patients (or their caretakers) have to buy their drugs outside the hospital. Private hospitals have their own pharmacies, and patients' total bill include the cost of drugs, where PhilHealth will make reimbursements.

Right now, there are other sectors that provide outpatient health insurance: local governments, cooperative or community health insurance, private health maintenance organizations (HMOs). Instead of PhilHealth covering outpatient and other expanded services then slapping us members with even higher mandatory monthly contributions, we better allow the other healthcare providers more leeway.

The last time I was hospitalized was about 27 yrs ago, when I was still in the university. Since I graduated and have work, I've been paying for Medicare, then PhilHealth, zero benefit for me. I have a private health insurance card in our office, that one is very useful. I use it every year -- for annual general check up (not covered by Philhealth), for outpatient consultations and diagnostic tests like if I have a bad cough

or fever. I see the value of my money in having a private health card.

I surrender to the fact that I have to part with my money every month for the mandatory PhilHealth contribution, but they should not make such contributions even bigger. Remember, from our monthly paychecks, there are plenty of mandatory deductions already -- personal income tax, Pag-IBIG fund (housing contribution), SSS fund (pension and other services contribution), PhilHealth, what else. For every increase in any of those mandatory deductions, our monthly take home pay becomes smaller and smaller. And to think that when we spend such take home pay, the government still collects another round of taxes like VAT.

There are many PhilHealth inefficiencies despite the limited coverage. Expanding the coverage will most likely expand the inefficiencies. PhilHealth -- like DPWH, DND, DepEd, DENR, etc. -- is a monster national bureaucracy. Monsters have a tendency to exist for themselves. That is why I don't really trust them.

Long queues at PhilHealth

When my wife gave birth to our 2nd child early last week, I needed to get her member data record (MDR) as one of the requirements for PhilHealth claims/deductions. I went to PhilHealth Quirino Ave. office to get it. The printing of that document should not take more than 1 minute, I guess. But the long lines just to get that MDR was que horror! About 30+ people queuing to get an MDR or PhilHealth ID and only one PhilHealth staff to entertain them all. It took me 1:40 hours just to get that simple document.

Does PhilHealth think that their members are jobless people who have nothing else to do and hence, can endure queuing for hours just to get simple documents, or file claims? I filed

a claim, again for my wife who was hospitalized about 3 months ago. Just to file the papers took me 2:05 hours. Then we will wait at least 60 working days to get the claims.

People endure the slowness of PhilHealth bureaucracy when members get their rightful claims after religiously paying their mandatory monthly contributions for years. There is a poster inside that members can send in their contribution by texting. When you send your contribution, PhilHealth wants to get it within seconds or minutes. When you get your claims, PhilHealth wants you to wait for hours queuing, and several months waiting for the actual claims.

Now we are resigned to the fact that PhilHealth's universal coverage will become even bigger, fine. The poor deserves healthcare. But do we all pay bigger mandatory monthly contributions? Do we all endure even longer queues and longer waiting period to get PhilHealth benefits?

The future is not yet here but I think the answer to my own questions above are all Yes. Endure more ugly government bureaucracies.

23. Market segmentation vs. central planning, health sector

16 October 2010
www.thelobbyist.biz

Market segmentation is respecting the diversity among consumers who have different needs with different goals and different budget and resources. It allows price and product differentiation. Central planning abolishes market segmentation and price differentiation. There is one centralized service provision at a standardized and homogenized service standard or quality at homogenized budget and price. Where there is uniformity and homogenity, what follows next is mediocrity.

In food sector, there is no government carinderia or restaurant corp., no government supermarket agency, no government fish and vegetable seller or fastfood chain or turo-turo corporation, no government food insurance corporation. And people are eating.

In health, there are thousands of government rural health centers, thousands of government-sponsored “botica ng bayan” and “botica ng barangay” (village pharmacies), hundreds of government hospitals run by both national and local governments, there is government health insurance corporation, there is government drug price control policy, government mandatory drug discount policy, various health programs -- and health problems are expanding.

What explain for this difference? Market segmentation. In food, clothing, shoes, buses, shipping lines and airlines, there is price and product differentiation The rich get more pricey services while the poor and middle class get less glamorous but nonetheless get certain services at a lower price. The poor's P20 per meal does not mean that it is less nutritious or it is poisonous, compared to the rich's P1,000 or

more per meal. There is a market for everyone along different income groups, along different geographical units.

When government comes in like in healthcare, market segmentation and differentiation is generally abolished. There is no incentive to provide extra good care, extra effort to please and serve the public. The salary and bonuses are the same anyway, whether one serves 30 or 50 people, so why serve 50? This explains why the lines and queuing in many government offices and health centers are long. Perhaps this will discourage more claims for government benefits, like PhilHealth claims.

There is danger in relying too much on centralized government service delivery. Market segmentation allows people to jump and choose from one service provider or food seller to another, until they find one that serves their need and budget. There is public welfare here.

The drug price control policy is another classic example of how central planning can lead to rigid and inflexible decision making. Since June 2009 up to early this year, there have been many meetings by the DOH Advisory Council on Price Regulation. Being one of the four members from the CSOs, I have attended most of those meetings. Speakers from the industries -- local pharma, multinational pharma, hospitals, drugstores, pharmacist association, physician association -- are one in saying that price control does not achieve its goal of making essential, branded (and sometimes patented) medicines affordable to the poor. But the policy is still intact until now, zero sign that it will be pulled out by the DOH.

Fifty percent of X is still "expensive" for the poor because the poor want the price to be zero. The rich and middle class are jumping with lots of savings from continued patronage of branded products by the multinational pharma. And we thought that the DOH is heavily promoting generics drugs, not branded drugs? Watsons and other drugstores' data are

showing that more and more people are switching back to branded drugs by multinationals. This seems to be the new goal of the DOH now.

Government should learn to step back and allow competitive service provision and pricing by different product and service providers. Government should also step back from intrusive and distortionary high taxation.

24. Mandatory drug price cuts

(This is a merged and slightly revised paper of my two articles, **Mandatory drug price discounts** last November 3, 2010, and **Drug price control or decontrol**, posted in www.thelobbyist.biz last November 17, 2010)

Last week of October, I attended the first meeting of the DOH Advisory Council for Healthcare. This body used to be called the "Advisory Council for Drug Price Regulation."

Curious why a free marketer like me is attending meetings of the government that imposed drug price control? Well, I attend them mainly to listen to what the industry players have to say based on their actual experience, and to help explain to the DOH officials that price control is not the way to achieve the goal of cheaper drugs or whatever commodity. More competition from more players will achieve that.

Anyway, the various industry players were there in the meeting as usual -- the multinational pharma, local pharma, drugstores (from Mercury to Watsons to small ones), hospital associations, medical and pharmacist associations, NGOs. There were also participants from other government agencies like the DTI, Food and Drug Administration (FDA), and PITC Pharma.

The old and renewed pain of the drug retailers were raised once more related to the obligatory, mandatory discounts for senior citizens (SC) and persons with disabilities (PWDs). And recently the expanded senior citizen law.

Before, it was 20% mandatory discount (SC and PWDs). Then there was the drug price control policy, mandatory 50% discount. And after that, the expanded SC discount of 12%

So drugstores, especially the small ones, that earn a gross profit margin of 5 to 10 percent will now be forced to

shoulder the above mandatory price reductions at no cost to the government. All costs will be borne by the drug retailers and drug manufacturers. The mandatory revenue losses are not subject to tax credits.

When politicians like legislators think of "welfare", one variation is that the full cost of such welfare is entirely on the sellers and entrepreneurs, not on them or the Executive branch. Let the drugstores (small ones, esp.) lose and close shop, or let them stop selling some affected drugs, or let them sell cheap but counterfeit drugs perhaps to help recover the losses, they won't care. So long as they can "give welfare" at no cost to them or to the national treasury.

The other and more dominant variation of welfare, is that taxpayers foot the bill, like the conditional cash transfer (CCT) and various other programs.

Welfare. Politicians are well, taxpayers pay the fare. Welfare.

Drug price control or decontrol

The purpose of price control of any commodity by any government, is to make that commodity more affordable and more accessible to the poor. The immediate goal is price reduction, without thinking much of whether product supply or product quality may be adversely affected later.

Drug price control and regulation has been with us for the past 15 months now. All players so far have somehow adjusted to the reality that the policy is here to stay for the next months more, or even years. So the innovator pharma companies have resorted to various cost-cutting like laying off some staff and reducing the floor space of rented offices. Generic and local pharma companies have resorted to either further price reduction to their already low prices, or pulling

out from the market those drugs whose price can no longer be brought down further.

The poor have actually benefited already from the dynamic competition among various drug producers in the country as most drug molecules are already off-patent and can be produced by many generic manufacturers under different product names. So when the government forced the 50 percent mandatory price reduction for several branded drugs by multinational pharma companies, the poor did not benefit much, but the rich and the middle class benefited from such move as they now enjoy a 50 percent discount to drugs that they are going to buy anyway even if the price is deemed "high".

What was affected was the more than two-decades long promotion of generic drugs by the DOH. Many middle class consumers shifted back to the branded drugs by innovator pharma companies as their prices have become lower.

DOH UnderSecretary for Policies, the official directly in charge with implementing and monitoring the drug price regulation policy, Alex Padilla, told me in an email exchange (he gave me permission to quote him on this) that

"There were mixed results and that the voluntary price reductions have actually led to some competition and further lowering of some prices, including the generics. In many respects, the medicines affected by the price reductions are now relatively at par with other ASEAN prices."

While the general lowering of drug prices in the country is "good news", what was removed from many public discussions is the impact on the investment environment of the country in general, and the pharma sector in particular.

I think the long term damage will be on how innovator companies will look at the Philippines. One possibility is that

if they have new, more powerful, more disease-killer drugs, they will bring those in HK, Singapore, Japan, S. Korea, others where there are no threats of price regulation or CL and other IPR issues, but not in the Philippines. So only old drugs or still patented but with only about 2 yrs left in the patent life, will be brought in here. For those desperate to get the new and more powerful drugs, they may have to buy them abroad, or they may have to travel abroad to seek treatment. Either case, it will make treatment become more expensive.

25. PhilHealth's P110 B excess money

04 November 2010, www.thelobbyist.biz

Here is the government's health insurance corporation monopoly amassing P110 billion (about $2.5 billion) of reserves and extra money, but giving out very limited services to its contributors who were coerced to become members. In addition, the quality of service is lousy.

I have personal experience of queuing for two hours just to submit documents for benefit claims -- a process that takes only about one minute when you talk to the PhilHealth staff; or queuing for an hour and 40 minutes just to get a member data record (MDR) -- a process that takes only about 30 seconds.

There have been a number of recent big conferences and symposia on attaining universal health care (UHC) for all Filipinos. The most recent was the two-day summit on UHC held on October 27-28 at the Ramon Magsaysay Center sponsored by MeTA Philippines, in partnership with the DoH, WHO and AIM.

A week before that, there was a one-day forum on the same subject held at the AIM and sponsored by the Zuellig Family Foundation. A month ago, there was two-day forum on the same subject held at the AIM, sponsored also by MeTA Philippines. Among health NGOs, the Coalition for Health Advocacy and Transparency (CHAT) also held several forum on the subject over the past few months.

The DoH Advisory Council for Price Regulation, the council hearing inputs on the drug price control policy of the government, has been converted into the Advisory Council for Healthcare. I am a member of that old and new Council and the first meeting of the new Council was held only last Tuesday, October 26, at the DoH compound.

So, what should PhilHealth do to spend the P110 billion for its members, and not invested in government treasury or other unrelated activities?

One measure that I can think of, is for PhilHealth to outsource the function of (a) giving out PhilHealth membership cards, (b) printing of MDR, (c) receiving documents for claims and other related work. The institution should focus its personnel and efforts on checking claims to reduce waiting period from 60 working days (at least) to only a week or two and to remove, investigate and prosecute fraudulent claims -- or other core function related to expanding and hastening payment to members.

Another is to cover out-patient consultation by members, say to see a physician. Diagnostic tests for out-patient care may need not be covered for now. The main reason why many people resort to self-medication (if they feel ill, they immediately go to a drugstore to buy drugs that are heavily advertised or was recommended by their friends and family members) is because they do not want to pay to see a doctor, unless their illness is already serious. Self-medication often results in irrational drug use.

Members should feel that they are getting some service from the monthly contributions they are coerced to give to PhilHealth. This way, they will pay with a light heart, and not feeling like being held up monthly by another government bureaucracy.

26. New drugs, patents expiring and upcoming ones

18 November 2010

Diseases evolve, so treatment must also evolve. As new diseases are discovered, or old diseases emerge as a hybrid disease, new medicines and vaccines must be discovered and produced to treat or kill such new diseases. Hence, the need for medicine innovation.

Patents and other forms of intellectual property rights (IPRs) help provide the incentives to medicine inventors and innovators. The "monopoly period" of 20 years patent life -- minus 10 to 15 years in various phases of clinical trials and approvals by government regulatory agencies, or net "profit period" of 5 to 10 years -- is supposed to help the drug innovators to recoup their huge R&D costs and make profit.

I read from a physician, Dr. James Gillespie, **Valuation and the India pharmaceutical sector**, www.asiahealthspace.com/2010/09/13/valuation-and-the-india-pharmaceutical-sector/, that "In the next 4 to 5 years, drugs worth $80bn will go off-patent. This will open tremendous opportunities for firms in low cost countries such as India to successfully compete with their generic versions of off-patents."

Wow, that's a huge opportunity for the generics manufacturers. And good opportunity for patients to enjoy cheaper medicines from more generics companies competing with each other.

But if so many drugs are losing patent, to mean partly that they are getting older while new diseases are being discovered or are evolving, where are the new drugs?

According to "New medicines in development", http://innovation.org/index.cfm/FutureofInnovation/NewMedicinesinDevelopment,

> Today, over 2,950 new medicines are in development. Many of these potential new medicines will fail in clinical trials, but some may represent tomorrow's new treatments. Bringing each new medicine to patients will require, on average, 10 to 15 years of testing and review.[i]
>
> This database includes medicines currently in clinical trials or at FDA for review. The information contained in this database was derived from Wolters Kluwer Health's database http://www.wolterskluwerpharma.com/ and is published with permission under license with Wolters Kluwer Health.

That is something that many patients can look up to. There are old, cheaper drugs and treatment that are available from competing generics producers. And there will be new, patented and more expensive drugs that will be made available by a few innovator companies. Price will definitely be an issue, no question about that. But it's saving the life of a loved one that is the bigger issue.

27. Patents, Politics and Personalized Medicines

07 December 2010,
http://manilatimes.net/index.php/opinion/34120-patents-politics-and-personalized-medicines

Diseases evolve, patients' expectation of getting cured evolve, and so treatments and medicines also evolve.

Nothing is stagnant, everyone and everything keep changing, from disease virus and bacteria to physicians and patients. The issue of patents on newly-developed medicines by big multinational pharmaceutical companies remains a ticklish and emotional issue up to this day. Certain groups simply think that developing new medicines which they expect to be effective disease killer and safe at the same time only cost a few thousand or a few million dollars.

Thus, these should be sold as cheaply as possible. Or if the drug inventors will resist, governments should confiscate their invention and make it "others' invention" as well so that those who did not spend a fortune on expensive R&D can manufacture those drugs as cheaply as possible.

Here in the Philippines, despite the provision in the Cheaper Medicines Law (RA 9502) that allows the government to confiscate the patent of certain important drugs via compulsory licensing (CL), there is little or no reason to rush its implementation. Not because the Philippine government and its politicians suddenly realize the negative long-term effects of heavy intervention like drug price control and confiscation of patents of costly drugs R&D. But because there are very few patented drugs now in the market, and the patent life of the few patented ones that are left is short already.

What we have now is the mushrooming of many generic manufacturers and traders in the Philippines and other

developing countries. And all of these companies are beneficiaries of previously patented drug molecules whose efficacy and safety were discovered by the innovator companies.

Still there are global moves to kill drug patents as often as possible. The operative slogans are “patient over patent” and “people over profit,” as if there is inherent contradiction between the two, and as if there is no contradiction between unproductive bureaucracies and the public.

Given this reality of constant political threats, innovator drug companies have various options. One is to quit being a drug innovator and become an average generic manufacturer, or move to inventing new shampoo, new skin whiteners, new breast enlargers and other personal care products that are not subject to politics and envy.

Two is to continue drug innovation, but limit the sale of newly patented and more revolutionary drugs to countries that respect private property rights. Patients from the Philippines and other developing countries that are likely to declare price control or CL will not have access to such drugs, they will have to buy those from Hong Kong, Singapore, Japan, US and other countries that respect private property rights.

And three, continue innovation for personalized medicines. The latter is a new approach utilizing biomarkers to evaluate compounds in the drug discovery process for various patients. The new development is that all of the biopharmaceutical research companies that were surveyed in the US by the Tufts Center for the Study of Drug Development at Tufts University, are now investing in personalized medicines. See their press release, http://campaign.r20.constantcontact.com/render?llr=dfmcosn6&v=001iXIUy3Vz-XxtROhsjrqW1FDyhclq_qbAPqMR5mCTW17JmXrqvvtxTT4VhXcSgRMmyxuub2dakLYgSh07W6Eef7WLsGj2gNsR_sK7

-eOR8EVxWQdZ__zE6fTgbl-27riXEAFwsoTVfHG8tAii4YKAJA==.

The implication here is that in the treatment of a particular disease, say prostate cancer or hypertension, there will be many new medicines that will be developed that are tailored to certain patients and which will not be applicable to other patients suffering from the same disease. Thus, for every 1,000 patients who suffer hypertension, there will not be one or two or five different drugs against hypertension, but probably 30 to 50 different drugs.

If there are 30 to 50 newly patented, newly developed drugs against hypertension alone, and there are 30 to 50 newly patented drugs against prostate cancer alone, which of them will be issued price control or CL by an intervention-itchy government? The top five most popular drugs, or top 10, or all of them?

As political intervention evolve, health innovation also evolve. And pretty soon, governments will only succeed in discouraging medicine innovation for new diseases that afflict the poor.

To prevent this from happening, governments should rein in their itchiness for endless intervention. And more innovator companies will sprout, to cater to various patients with various health needs and various and buying capacities. And public health will be served better.

28. AsPac pharma market and government

07 December 2010

There is a good article on the global and Asia Pacific pharma market yesterday by Dr. Tej Deol, **The APAC pharma markets; connecting the dots by Jan-Willem Eleveld, Vice President Consulting & Services IMS Health** http://www.asiahealthspace.com/2010/12/06/the-apac-pharma-markets-connecting-the-dots-by-jan-willem-eleveld-vice-president-consulting-services-ims-health/.

It's about a presentation by Mr. Eleveld, IMS' VP, last October this year. Dr. Deol showed 10 slides from Mr. Eleveld's presentation.

By 2014, the global pharma market is projected by the IMS to reach some US$ 1.2 trillion, from an estimated $850 billion this year. The "Pharmerging" markets are projected to have $260 to $290 billion sales by 2014. The list of those "pharmerging" economies though does not include the Philippines. Thailand, Indonesia and Vietnam were included.

The Asia-Pacific region excluding Japan, is projected to have 17 percent of global pharma sales by 2014, up from only 8 percent in 2005 to 11 percent this year. Japan will keep its estimated 13 percent of global share up to 2014.

The generics market will keep its rapid growth, which is a good response to high consumer demand for generics, branded or non-branded. This sector has grown from $28 B in Q3 2006 to $55 B in Q2 2010, or a doubling of sales in just 4 years! The innovator drugs have also experienced growth, from $14 B in Q3 2006 to $23 B in Q2 2010.

In terms of annual growth rate, while the originals experienced 11 percent growth from 2006 to 2010, branded generics grew by 15 percent and unbranded generics grew

by 19 percent over the same period. At this growth rate, innovator companies will consider moving into generics manufacturing because of the huge business potential due to high consumer demand for cheaper generic drugs.

The list of Asian countries with government-mandated price regulation, euphemism for price control, includes India, Vietnam, Indonesia, Philippines and China. The degree or mechanisms of price control differ among these countries though. Malaysia has no price control yet, but the possibility of the policy being imposed there remains. And Thailand has no price control policy, but it has imposed compulsory licensing (CL), which has a similar negative effect on innovator companies.

A chart shows a new trend in some Asian countries -- the movement from "self-pay" to "semi-reimbursed" markets. Wider government health insurance coverage is projected to make this possible.

Semi-reimbursed or fully-reimbursed markets do not mean that only the government will provide the universal health insurance. Private and non-profit health insurance corporations or organizations can also do the job. But in most if not all policy proposals being considered in the Philippines and other Asian countries, only bigger government is being considered.

Healthcare and health insurance should take a cue from the pharma sector. There is no government pharma company except in Thailand, but the competition among many private pharma companies -- innovators, branded generics, non-branded generics -- result in lower prices of drugs as more drugs at declining prices are being introduced. It is actually government taxation of medicines -- like import tax (5 percent) and value added tax (VAT, 12 percent) as in the case of the Philippines -- that contributes to expensive medicines.

29. Compulsory licensing deviation

09 December 2010, www.thelobbyist.biz,

Compulsory licensing (CL) is a policy tool by the State to use an invention by someone which has been granted intellectual property rights (IPR) protection like patents and trademarks, and give it to other people or groups without the IPR holder's consent, purportedly to address some issues affecting "national interest".

In short, the State grants a property rights protection then removes or violates the same right it has invented and granted. This speaks how the State respects or disrespects the rule of law.

While CL can be applied in various IPR products and inventions, it gains notoriety in medicines. Global trade agreements even include TRIPS flexibilities where CL can be more easily declared and imposed by any developing country government.

My two good friends in Britain, Alec van Gelder and Philip Stevens, co-authored a new paper, **The Compulsory License Red Herring,** www.minimalgovernment.net/media/compulsory-201011.pdf. This 18-pages long paper was published by the International Policy Network (IPN, London) last month and deals with repeated pressure by certain groups to declare CL to several anti-HIV/AIDS drugs that are still patented.

In this paper, Alec and Philip argued,

> …While it is true that few compulsory licenses have been issued in the past decade, access to medicines has increased rapidly… While there remain considerable barriers to access, these have little to do with IPRs. IPR standards have improved in many

regions – and this may actually have increased access to medicines in general and ARVs in particular.

The following facts are apposite:

* 65% of first-line anti-retroviral medicines are now produced by generic manufacturers;

* Many second- and third-line ARVs that are protected by patent rights are being manufactured in India and other developing countries with rights-holders consent.

* Many other first-, second-, and third-line medicines protected by patent holders are being manufactured in India without the consent of rights-holders, yet these companies have to date not registered legal challenges to this production.

* Options to promote access and to encourage sustainable downstream R&D through differential pricing are being explored by the private sector.

IPR protection like patent is important because it allows the drug inventors who spent huge amount of money in expensive R&D, long and repeated clinical trials with various subjects (from animals to people), complying with various inspections and regulations by government drug administration office. Inventing effective and safe drugs is very costly and risky. The patent system allows the inventors to have exclusive use of their successful invention for x number of years, they can sell the product at a price that will allow them to recoup their expenses and make some profit.

When this kind of protection can be dishonored anytime, then potential inventors will be discouraged from further invention, or will be discouraged from bringing into developing country markets those useful drugs that are available in rich countries that respect IPRs.

Instead of discouraging inventors, the State should encourage more inventors, more innovator pharmaceutical companies, to develop more powerful, more disease killer drugs, and let them compete with each other. After sometime, the patent of those drugs will expire anyway, then even plentier generic manufacturers will produce the same drug molecule and sell at much cheaper prices.

The CL red herring or diversion is a non-productive exercise that saps more energy and resources of various sectors and players, energy that could have been used in more productive health activities like more public awareness and education about AIDS, more modern health facilities especially in rural areas, more preventive measures.

Bringing in the State to disrespect what the State has granted and protected in the first place, is one lousy way of using our tax money.

30. Drugs can heal, drugs can kill

16 December 2010, www.thelobbyist.biz

Drugs and medicines are among the highly emotional and political commodities in any society because they are associated with people's health, People almost always look at drugs as compounds or substances that can heal or cure them from their illness. Thus, the endless political intrusion in drug pricing, trading and manufacturing in many countries.

But do many people realize that while drugs can heal, drugs can also kill?

There are many ways that drugs can kill, directly or indirectly.

One is when patients take counterfeit or substandard medicines. The counterfeits are those that do not contain the necessary ingredients and hence, cannot deliver the substances to control or kill a particular disease. Substandard drugs are those that contain the sufficient ingredients but at insufficient amount, usually below 80 percent of the required active pharmaceutical ingredients. When patients take these drugs, the virus, bacteria, or other disease molecules in their body either multiply or evolve to something more serious or more deadly. As days pass by, either the patient does not get well, or becomes even more sickly.

Two is when patients take the correct, non-fake, and manufactured at good standard drugs, but mis-stored and mis-handled, reducing their efficacy and safety. For instance, drugs that should be stored at 20 to 30 deg. C at all times, when brought to a place at 31 C or warmer for an extended period of time, will lose their full efficacy and safety. These drugs may deliver the same negative result as taking the fake or substandard ones.

Three is when there is irrational drug use. When patients self-medicate and take just any drugs that they heard from other people or saw in tv or billboard advertising, without professional supervision by a pharmacist or a physician. This case happens more often if drugs are given away for free or are sold cheaply. So patients may take the wrong drugs, or the right drugs but at the wrong dosage, and so on.

Four is when patients take expired drugs and hence, have almost zero efficacy and are unsafe. These drugs may be in some cabinet in the house for a long time, or given away for free by some local government units but the drugs are not well-supervised and monitored by professional pharmacists. There have been reports where useful drugs, expired drugs, cockroach, garbage and other dirty materials are mixed up in one room with no temperature control by some municipal or city or provincial pharmacies.

Five is when patients take drugs that are well-stored, well-handled, produced at good manufacturing practices, but were developed in other countries and continents. The various clinical trials have been conducted on people from the tropics or poorer countries in the temperate zones, the trials produced good results, but may have harmful results on patients in the northern hemisphere and richer countries. This is a tricky subject, and there is a long discussion about this at "Deadly Medicines", http://www.vanityfair.com/politics/features/2011/01/deadly-medicine-201101?currentPage=all. I suggest that readers visit that article.

There should be other factors that can contribute to "drugs can kill" cases. That phrase actually came from a Filipino pharmacist friend who emphasized the importance of professional supervision by trained pharmacists and physicians when people are sick.

So the next time we are sick, we should not take just any drugs that we heard from friends or we saw on tv or newspaper or billboard ads. Perhaps we may not need drugs at all, perhaps we may need only more rest, more water, and less or zero undesirable food and drinks that can trigger some adverse health results in our body. Seeking health professionals' advice and maintaining healthy lifestyle will produce better health outcome, than just taking any drugs, even if these drugs are priced very low or given away for free.

31. Cancer-fighting food and drugs

30 December 2010, www.thelobbyist.biz

Christmas is over, but the eating and partying galore is not, as we approach the new year. Like “drugs can heal, drugs can kill”, it can also be said that “food can heal, food can kill.” Eating too much of non-nutritious food can cause future diseases in the body – from hypertension to high cholesterol to cancer.

Cancer is now the number one disease that I am watching, for personal reasons: my elder brother, my sister-in-law, my mother’s first cousin, one of our wedding godmothers, have all died of cancer. Another wedding godmother is now seriously fighting for her life in a hospital because of that disease. And at least 3 friends now have their respective fathers undergoing various anti-cancer treatment. There seems to be so many people who are sick or who have already died of cancer.

I saw a yahoo news article today, **cancer-fighting superfoods**, http://shine.yahoo.com/event/vitality/6-cancer-fighting-superfoods-2428408/.

It immediately caught my attention. Here are those six great food, according to that news report: broccoli, berries, beans, garlic, tomatoes and walnuts.

Broccoli is known to have a “sizable amount of sulforaphane, a particularly potent compound that boosts the body's protective enzymes and flushes out cancer-causing chemicals, says Jed Fahey, ScD.” This vegetable helps fight breast, liver, lung, prostate, skin, stomach, and bladder cancers.

Berries “are packed with cancer-fighting phytonutrients. Black raspberries contain very high concentrations of

phytochemicals called anthocyanins, which slow down the growth of premalignant cells and keep new blood vessels from forming (and potentially feeding a cancerous tumor).” This vegetable helps fight colon, esophageal, oral, and skin cancers.

Beans, a study out of Michigan State University found that :black and navy beans significantly reduced colon cancer incidence in rats, in part because a diet rich in the legumes increased levels of the fatty acid butyrate, which in high concentrations has protective effects against cancer growth.” This vegetable helps fight breast and colon cancers.

Garlic contains phytochemicals which “halts the formation of nitrosamines, carcinogens formed in the stomach (and in the intestines, in certain conditions) when you consume nitrates, a common food preservative.” This veggie helps fight: breast, colon, esophageal, and stomach cancers

Tomatoes are the “best dietary source of lycopene, a carotenoid that gives tomatoes their red hue, Béliveau says. And that's good news, because lycopene was found to stop endometrial cancer cell growth in a study in Nutrition and Cancer. Endometrial cancer causes nearly 8,000 deaths a year. This veggie helps fight endometrial, lung, prostate, and stomach cancers.

Walnuts have phytosterols that are “shown to block estrogen receptors in breast cancer cells, possibly slowing the cells' growth, says Elaine Hardman, PhD, associate professor at Marshall University School of Medicine in Huntington, West Virginia. This veggie helps fight breast and prostate cancers.

These are just among the nutritious foods that we should eat more to help reduce the likelihood of getting any of those cancer diseases. But cancer is inevitable. Somehow sometime, some of us will get that disease. What do we do? Get anti-cancer treatment.

There are plenty of existing anti-cancer drugs, vaccines and other forms of treatment. But they are not enough. Cancer cells are never static. They can easily mutate and evolve, from one case to another, from one patient to another. A particular anti-cancer drug can cure one patient but not another patient suffering from the same type of cancer because of certain genetic differences among people.

Thus, anti-cancer drugs and vaccines need to evolve too. I saw another article, **New Report Shows More Than 700 Medicines In Development by New York Companies** http://www.phrma.org/new_report_shows_more_700_medicines_development_new_york_companies. This is a good development.

With the new year approaching, I also hope that our appreciation of important researchers and inventors – like those researchers of anti-cancer food and anti-cancer drugs – will improve. We tend to attack them as plain "profit-hungry capitalists" who benefit from dying patients without realizing the value of their work to us and our loved ones who are in need of more revolutionary health treatment.

Extra: International reports where Mr. Oplas was interviewed and quoted

Report from: the Philippines

New pricing controls and healthcare reforms may be pushing the pharmaceutical market out of this southeast Asian country. This article contains bonus online-exclusive material.

Nov 2, 2009
By: Jane Wan
Pharmaceutical Technology
Volume 33, Issue 11

http://pharmtech.findpharma.com/pharmtech/article/articleDetail.jsp?id=639208&sk=&date=&&pageID=1

…. Healthcare policies aside, industry's primary concern about the MDRP system is that it may turn the tables on domestic firms. **Nonoy Oplas**, president of the Minimal Government Thinkers, a group of professionals and small entrepreneurs, says, "Local firms who are producing drugs under the 21 molecules will become more expensive sellers now. To remain competitive, the natural response is for them to slash prices between 10-20%, which will reduce their profits."

He adds, "Domestic firms do not enjoy economies of scale due to high production costs. Eventually, many will be forced out of business. Unlike multinational companies (MNCs) who can divert their attention to other markets, home-grown

companies have fewer product offerings and do not have other market avenues."

On the other hand, it appears that foreign firms are likely to grow in the long run. Although their product prices are affected as well, the Philippine market is considerably small (about 5% of the global sales of multinational corporations) and, these companies can afford to divert their attention to other markets. They already hold a lead in manufacturing and retail revenue, according to 2008 PHAP figures. Foreign firms garnered total sales of PHP71.12 billion ($1.46 billion) compared to local ones at PHP32.46 billion ($0.69 million).

Oplas believes that foreign drug manufacturers should feel encouraged to remain on Filipino soil to help develop the local pharmaceutical industry. The majority of MNCs in the country are focused on drug discovery, which can, in turn, create opportunities for local firms to produce generic versions when innovator-drug patents expire….

Ultimately, patients are the losers. "We are likely to expect a fall in the number of generics companies and medicines in the country, which in turn, limits treatment options for doctors and patients," says Oplas. "Also, it is also possible that a black market emerges when storage, dispensation, and sale of essential medicines are no longer transparent [or competitive]. This paves the way for the entry of counterfeit drugs that are perfect substitutes for effective and expensive medicines."

Philippine Price Controls Hamper Rise of Generics

Wall Street Journal
JUNE 18, 2010
By JAMES HOOKWAY

http://online.wsj.com/article/SB10001424052748703340904575284061202593520.html

MANILA—The Philippines recent embrace of drug-price controls to lower the cost of life-saving medications is creating some unexpected problems—including crimping the supply of inexpensive generic drugs.

The country's president, Gloria Macapagal Arroyo, was eager to reduce the cost of pharmaceuticals in a nation where a third of its 95 million citizens live on around $2 a day. Last August, she used new regulations to cut the cost of five widely used medications, including Pfizer Inc.'s Norvasc hypertension drug and GlaxoSmithKline PLC's Augmentin antibiotic….

Edward Isaac, executive director of the Philippine Chamber of the Pharmaceutical Industry, said price controls and the threat of more caps have lowered the cost of some brand-name drugs to near those of generic competitors. Pfizer's Norvasc was cut to about 22 pesos, or 47 cents, for a five milligram tablet, from over 44 pesos.

"What's happening now is that when the price of Norvasc, for example, is cut, the generics have to slash their own prices," Mr. Isaac said.

Declining profits have some drug retailers putting expansion plans on hold. "We've not opened any new stores since the price controls were introduced," said Leonila Ocampo, vice

president of Manila-based MedExpress. The drugstore chain has seen sales volumes drop since the price controls were introduced. "Our margins are under pressure, and if there's no profit, I don't know what will happen," said Ms. Ocampo.

Another drug store operator, Florecita Intal of Stardust Drugs & Medical Supplies Corp., said lower revenues from the branded-drug price caps restricts her ability to expand and offer less expensive generics. She fears smaller retailers might not survive.

While brand-name drugs still account for a large proportion of the drugs market here, generic competitors were beginning to gain in popularity, driven by the spread in recent years of generics-based chain stores up and down this densely populated country.

Data collected by Mr. Isaac's organization indicate, however, that the value of all drugs sold dropped 15% from August 2009 to February 2010, while the volume of pharmaceutical sold here held steady.

Bienvenido Oplas, head of the Manila-based Minimal Government Thinkers Inc. think-tank and a member of the consultative panel advising the Philippines' Department of Health, said this means the price controls policy just isn't working. "It hasn't fulfilled its objective of making more drugs available to more people," he said....

Philippine Drug Price Controls Pinch Brands And Generics

- Ying Huang (pharmasia@elsevier.com)

June 25, 2010

http://bit.ly/hx2Abx

SHANGHAI - State-mandated price cuts in the Philippines on branded drugs are putting some generics makers in a tight spot. The government price controls, which began in August 2009, have spread swiftly, and the caps affecting commonly prescribed drugs are now pressuring their generic competitors.….

Bienvenido Oplas, president of the Manila-based think tank Minimal Government Thinkers and a member of a consultative panel advising the Philippines' Department of Health, said the price control policy does not promote access to more drugs.

"The poor who did not buy the branded drugs prior to price control still did not buy those drugs after the price control. The prices of some generic drugs of the same molecule were still a lot cheaper than the already half-priced branded drugs," Oplas said.

"Those who were buying the branded drugs prior to price control were the same who bought those products after the price control. A half-priced product does not mean that they will take two tablets instead of just one because these are prescription drugs, not over-the-counter drugs," he added.

According to Oplas, ***Norvasc*** (amlodipine) was at PHP44 (95 cents), later became PHP22 (47 cents) after the price control, but it is still expensive for the poor who buy the cheapest generic at only PHP8 (17 cents).

It is anticipated that sales of generic drugs will see a considerable rise in the country, reaching $800 million by 2012, according to Business Monitor International.

Musciacco attributes generics growth to recent government measures to incentivize their use. The Philippines pharma market is currently dominated by foreign branded companies while generic products have historically achieved only a minority share of the market due to lack of public awareness and confidence in generics….

Drug price controls, while lowering the cost of life-saving medications, are bringing unintended consequences and challenges in the industry for both innovator and generic companies.

"For the innovator companies, a cloud of uncertainty is hanging in the sector and the economy," Oplas said. "Some of them may consider not bringing into the country their newer ... drugs, which still have long patent periods left, as the risks of another drug price control and issuance of compulsory licensing and parallel importation will always be a possibility."

"For the generic companies, there is also a cloud of uncertainty about how to further bring down their already low prices if another round of price controls is declared in the future without going bankrupt," Oplas said....

About the Author

Bienvenido “Nonoy” Oplas, Jr. is the founder and President of Minimal Government Thinkers, Inc. (www.minimalgovernment.net), a free market think tank based in Manila, Philippines. He graduated from the University of the Philippines, School of Economics (UPSE) for his AB Economics (1985) and Diploma in Development Economics (1998) degrees.

He was introduced to politics as one of the many student activists in UP in the early 80s, been enamored by Marxist-socialist ideas, belonged to a socialist organization after graduation, worked at the House of Representatives’ economic think tank, then in a private consulting firm Think Tank, Inc. Thus at one time of his life, he also advocated health socialism and did not believe in the supremacy of individual freedom over collective freedom..

He started blogging in late 2005 at http://funwithgovernment.blogspot.com. He is also writing a weekly column in the online magazine www.thelobbyist.biz for the last two years, then in a weekend tabloid circulated in southern Metro Manila, the **People’s Brigada News** in 2010.

He is married and has two young daughters.