Promoting Innovation and Public Health Through Less Government Intervention

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I. Introduction

After many years of legislative and public debates, sometimes emotional and conspiratorial, on how to reduce the price of many medicines in the Philippines, RA 9052 or the "Universally Accessible Cheaper and Quality Medicines Act of 2008" finally became a reality. And like many attempts to bring down the price of food, houses and house rental, oil, electricity, etc., the standard mechanism is more government intervention and regulation like price or profit or rent control.

This paper is about the role of innovation in society and why innovation is important and must be encouraged. In particular, the role of medical and pharmaceutical innovation in order to provide the people with newer and more effective medicines and healthcare to deal with evolving diseases in our evolving lifestyle, evolving communities and evolving environment. In the process, public health is improved, which can lead to more economic development and poverty alleviation.

Then the paper will discuss what measures should be taken and what measures should NOT be taken by governments, in order to facilitate more innovation in society, with the provisions of the Philippines' new "cheaper medicines" law or RA 9052 as examples and discussion points. By doing this, it is hoped that (a) some pitfalls in the law can be corrected when policy makers draft and product the implementing rules and regulations (IRR) of the law, and (b) people and policy makers from other countries who are

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contemplating of following the “Philippine legislative example” can be better informed, if not forewarned.

Much of the discussions here are carry-over of the earlier paper produced by this writer in February 20, 2008 entitled “Making Medicines Affordable: The Role of Innovation, Competition and Taxation”.

II. Innovation and Development

Societies develop because of continuing innovation of citizens. New innovations on old inventions as researchers discover new facts and understand the atoms and molecules of their subjects make the new inventions more effective and more powerful for the ever-expanding needs of the people. Thus, countries that have plenty of innovations in communication and information technology have the edge in modern gadgetries for its people. Countries that have more innovations in agriculture and biotechnology have more food security and more food choices for its people. And countries that have more innovations in medicines and health care have citizens who are healthier and more productive economically.

On the other hand, societies can stagnate if there are plenty of disincentives to innovation, like over-regulation, monopolization, high taxation, price controls and disrespect of property rights of the innovators..

With the current spiraling of prices of almost everything, people look for ways to have some respite. People looking for cheaper food, cheaper oil, cheaper shoes, cheaper cell phones, cheaper medicines, and so on, is a perfectly rationale human behavior. Some people propose more government intervention, mainly more subsidies to some sectors and groups of people, to be financed from more or higher taxes. But other groups of people propose less government intervention and taxation, precisely to encourage innovation and flexible adjustment of people, both consumers and producers, to changing economic realities and social environment.

The development and protection of private property is among the cornerstone of a free and dynamic society. And in particular, the development of secure intellectual property rights (IPR) is among the best incentives for the composers, inventors and innovators of society. If their inventions are really useful and novel in supplying certain needs of the people, then the inventors can expect plenty of material and intellectual rewards, including enormous profit for their hard work.

Medicine innovation is an important area that must be undertaken by pharmaceutical companies if they want to remain relevant to the public, the physicians and patients in particular. Diseases evolve, so must be the medicines to eliminate or neutralize those new

diseases. Pests and insects in rice and other crops evolve, that is why agro-industrial companies or organic farming practitioners also innovate on new formulations or practices to neutralize those pests that can possibly wipe out a farmers' potential harvest. Cellular phone manufacturers never cease to innovate new models, discovering new uses to previously underutilized features of other cell phone models. Car manufacturers unceasingly innovate new models, like more fuel efficient cars, better warning and safety features, and so on.

Unfortunately, the public was made to accept that IPR of private innovators benefit only the multinationals who have the means and resources to undertake expensive research and development (R&D). Hence, IPR through patent can be weakened and shortened as much as possible. And the government, with the support of some activist groups and a few chosen private companies, can use the "secret formula" of the private innovators in the name of "national emergencies". Or governments should create their own innovator and R&D companies, operate without any competition and be splashed with endless subsidies from taxpayers' money. Their catchword in the medical arena is "patients over patents", which is similar to "people over profit", "equality over growth", and similar collectivist principles that sound good but disrespect individual liberty and diversity.

IPR is an important matter that should be respected and strengthened, not weakened or confiscated, if we want to encourage continuing innovation from productive people and enterprises – to have more food production, more fuel-efficient cars, more modern and affordable cell phones and laptops, more effective medicines, and so on.

III. Disrespecting IPR, the Philippine legislative example

Cheap and affordable medicines, generic drugs, are already available in the Philippines and other developing countries now. The only problem is that many of them are of dubious quality, do not pass bioequivalence testing for drug efficacy and safety, while some are outrightly counterfeit. In the observation of Dra. Suzette Lazo, faculty member at the Department of Pharmacology, UP College of Medicine, "not all generic drugs in the RP market have been tested; in fact only a very small minority has undergone this crucial testing because currently they are not required to do so." (Esposo, 2008)

The "affordable medicines" bill has been in the legislative mill for at least 8 years until it became a law, after a number of lobby groups have painted the multinational pharmaceutical companies as a bunch of "super-greedy" firms who only want more profit at the expense and suffering of the poor and sick Filipino patients.

In the new law, RA 9052, various factors suspected of contributing to the high price of medicines have been identified. Chart below summarizes the identification of problems and proposed solutions by the Cheaper Medicines Act:

Why medicine prices are high	Make medicines cheaper by
1. Current patent system under the Intellectual Property Code (IPC) favors multinational pharma companies, disadvantages generics manufacturers, prevents the production and marketing of new and effective but currently patented medicines.	→ Amending the IPC: (a) Disallow patents for new uses, new discovery, of existing substance if it does not result in enhanced efficiency. (b) Early working of a patented compound by a 3rd party, even without the patentee's consent. (c) Invoke "international exhaustion" of cheaper medicines abroad, sell drugs here via parallel importation even without permission by the local patentee; also, allow the importer to use the trademark even if he has not been licensed by the trademark owner. (d) Compulsory licensing & government use of patented product; especially if demand for product is not being met to an adequate extent and on reasonable terms. The patent holder be paid adequate remuneration. Legal cover – no court can issue a temp. restraining order (TRO) except the Supreme Court.
2. In cases of national health emergencies, no measures to regulate or control drug prices.	→ Empowering the President, upon the recommendation of the DOH Secretary, to regulate and control the maximum retail price (MRP) of certain drugs. The DOH Secretary has the power to require submission of documents, book of accounts, financial statements.
3. Weak Bureau of Food and Drugs (BFAD)	→ BFAD can retain all fees, fines, royalties and other charges to improve its operations, upgrade facilities, expand manpower, etc.
4.. Some local drug stores do not sell parallel imported drugs	→ Mandatory sale by all drugstores to carry parallel imported drugs to ensure access by the public.
5. Manufacturers of patented medicines have no generic counterparts	→ Amending Generics Law: require all drug manufacturing companies to produce unbranded generic versions of their patented medicines.
6. Current pharmacy law restricts drug retailing	→ Amending Pharmacy Law: allow sale of over the counter medicines in supermarkets, convenience stores, other retail outlets.

Meanwhile, a Quality Affordable Medicines Oversight Committee will be created in Congress composed of Senators and Congressmen, to conduct regular oversight review of the implementation of the law, complete with regular annual appropriation and new staff and personnel.

Those problems identified above miss the point. Even if these provisions are fully implemented, local prices of good quality medicines will remain high and unaffordable to many patients. What could be worse that can happen is that some of those measures will facilitate the manufacturing and distribution of cheap but counterfeit and ineffective medicines, which can endanger the health and lives of many patients.

IV. Patent and medicine prices

There is a prevailing public thinking that patents, especially by multinational pharmaceutical companies, are the main culprit why the poor do not have access to quality medicines and health care. It can be summarized as: "strong patent system = high medicine prices". References to India of having medicines "a lot cheaper" than those in the Philippines are often heard. But in India, only 20 percent of its total health expenditures goes to drugs. And all of India's 74 "essential drugs" are already generic or off-patent, so production is cheap. And yet, not all of these drugs are accessible to those who need them (Rozanski, 2007).

Expanding this example to the global market, World Health Organization (WHO) figures show that only 1 percent of WHO's "Essential Medicines" are patented, meaning 99 percent of them are already off-patent and their generic versions are already available. So if we follow the "patented = expensive" formulation, then 99 percent of those "essential medicines" should be affordable to the world's poor because they are already outside the patent system. How come that many poor people still cannot afford those off-patent drugs? The problem should lie somewhere.

Pushing further the "off-patent = cheap" line of thinking, and if only 1 percent (or even 5) of essential medicines is the problem, what could be the reason for altering the patent system for all medicines, including "non-essential" medicines, so that drugs for skin whitening, or medicines for eye-bag and wrinkles and wart removal, or drugs for fat-burners, breast enlarger, muscle development, height enhancer and related medications be made "more affordable" to the poor?

Let us review some of the measures and provisions contained in the new law as shown in the chart above.

(1) Prohibiting the granting of new patents to discoveries of new form or new property of a known substance, new use for a known substance; or new use of a known process.

Innovation is a continuing process. Sometimes the full potential of a new or known substance can be discovered and patented, sometimes not, and realization of their new uses and curative properties come later. As medical researchers' understanding of existing diseases expand, medicine innovators' discovery of new uses of existing medicines and substances also expand

By not recognizing as inventive step to new uses of known substances, the policy can reduce the incentives for drug innovators and research companies for continuing innovation and dampen their interest to explore further uses and new curative capabilities of known substances. In addition, this may pressure drug innovators to price their patented products at even higher levels during patent period to recover the expensive costs of R&D and bringing the product to the market. This is because effective "profitability period" of patented medicines is only around 7-10 years out of the 20 years life of a patent.

Consider this analogy too: you are an agri-biotech company. You have developed a rice variety that can help its consumers boost their immunity against malaria, tuberculosis, and diarrheal diseases. It took you many years of painstaking R&D, employing some of the brightest and most dedicated (and most expensive) scientists and researchers in the world. Because of the long period of R&D including biological and clinical trials, the "profitability period" under patent protection has become short. Naturally you should price your rice high, several times the price of ordinary rice, in order for you to recover the big expenses you spent and make some profit from your hard work.

With continuing innovation and exploration, you discovered that some substances in your rice variety can also boost a person's immunity against dengue or hepatitis. Meaning the nutritional and medical capacity of your rice variety just keeps on improving. But government will disallow you to have another patent and exclusive right to the new uses of your rice variety (ie, additional immunity booster against dengue or hepatitis). How would you feel?

Most likely you will feel bad. Meanwhile, non-innovators and copycat-ers come in to seize on the revolutionary uses and potentials of your rice variety, employ wonderful packaging and marketing schemes and sell at a lower price because they never spent huge amount of money in R&D and several years of trial and error phases. Some people will call this "more competition" among sellers of the miracle rice variety when in fact there

was only one or a few innovators and several dozen copycat-ers who just waited for the patent of the innovator/s to expire and jump on the bandwagon later.

Medicine prices under this scheme can come down, yes. But the incentives to innovators to develop a new round of revolutionary and "miracle" products that can improve public health in the long-run will be adversely affected. In the observation again of Dra. Lazo, "Drug development and manufacture involve very complicated technical processes and inputs from various scientific disciplines ranging from chemistry, pharmacy, molecular biology, statistics and medicine. Some drug molecules are more difficult to formulate than others and history is fraught with tragedies involving additions of excipient substances to the principal drug molecule."

Many people think that a patent life of drugs of 20 years are entirely "profit period". This is wrong. Once approved by a government patent office, the company that has submitted the innovation for examination must bring the new chemical entity through an extensive period of clinical trials. The experience in the US and Europe shows that regulatory hurdles in developing new medicines – several clinical trials, post-approval marketing, packaging, etc. – have increased dramatically. Clinical trials alone now eat about 8 to 12 years of the 20 years patent life. In effect this significantly raises the costs to bring a medicine to market.

With few innovators wanting to risk under this scheme, the price of future effective medicines will be very high. Overall, we cannot expect "cheaper quality medicines" to be available later on.

(2) Parallel importation allowed, importation and distribution of drugs bought cheaply abroad but under patent domestically, will be sold here even without the permission of the local patentee.

Parallel importation looks cute: the same medicines of the same dosage made by the same pharmaceutical company currently under patent in the Philippines are sold at only one-half, one-fourth, or even lower price, in India, Pakistan, China, or elsewhere. So, import those medicines even without the permission of the IP owner or patent holder and sell them locally. The local patients get cheaper medicines, importers make money, the State collects taxes, and there is supposedly no IPR or trademark infringement. Everybody happy, except the multinational pharmaceutical companies who are demonized to have made "enormous profit" as a result of their monopoly of their medical invention and innovation.

Drugs bought under parallel importation may have to be repackaged before distribution to local consumers to comply with local packaging and labeling requirements. Some unintended problems may arise such as incorrect or missing expiry dates, missing or wrong patient information leaflets.

The WHO estimates that about 30% of medicines supplied in developing countries are fake. India with more than 8,000 pharmaceutical companies, leads in counterfeit drug production, and has been estimated by WHO to have as much as 42% counterfeit rate. These fake drugs can easily find their way to the country via parallel importation.

In this light, one question that can be asked under this scheme is this: Supposing a patient develops bad allergies, if not died, after taking the imported medicines (maybe it's a fake or mislabeled or mistored or mishandled, that reduced or negated their effectiveness, if any) by non-patentees, who will be accountable? (a) the importer who brought the medicines, or (b) the foreign wholesaler, or (c) the foreign manufacturer, or (d) the local patentee who sells the same drugs domestically, or (e) the physician who gave the prescription, or (f) the government which allowed and encouraged the entire scheme? Unfortunately, the answer to this question could not be determined.

And finally, there could be cronyism involved in parallel importation scheme. Unlike in free trade where everyone with good personal and corporate reputation can thrive because of earning the trust of their customers through the years, not everyone can be accredited by a government agency in charge of promoting the scheme. Bureaucracies that decide who can do business and who cannot are likely to create inefficiencies and wastes somewhere.

(3) Compulsory Licensing and Government use, or appropriation of patented medicines or processes

Here, the state through the head of the Intellectual Property Office (IPO) can issue compulsory licensing (CL), without the permission of the IP owner, when "public interest, in particular, national security, nutrition, or health or the development of other sectors" so requires. Government or its authorized representative or subcontractor, can use or appropriate a medical invention.

Consider this hypothetical case: Supposing there is AIDS (or bird flu) epidemic in the country, even if the cases are isolated but the government has ruled there is "national emergency". From among many pharmaceutical companies that sell anti-AIDS (or anti-bird flu) drugs, one-fifth of those drugs can cure an average AIDS patient in about 10 years; another one-fifth can cure the patient in about 7 years on average; another one-fifth of the drugs can heal a patient in 5 years on average; another one-fifth can heal a patient in 3 years on average, and the remaining one-fifth can cure a patient in 1 or 2 years. But the price of the latter drugs is higher than the average price of the second one-fifth group of drugs, and much higher compared to three-fifth of all drugs that can cure a patient in much longer period.

Which medicines will likely be issued CL or declared "for government use", the cheaper but less effective drugs, or the expensive but more effective ones? You can bet your huge savings that it will be the latter. Which points to one ugly reality: the criteria in choosing which products will get the heaviest government regulation, in this case CL, is pure envy. And it will be safe to bet that if those top one-fifth, more effective but more expensive drugs, were never invented because their manufacturers and inventors have been driven and cast away as "profit-hungry devils", then government will go after the second-liner effective drugs for CL or other forms of IPR legalized theft.

If the manufacturers of effective but expensive medicines that were issued CL will protest since they have not fully recovered their sky-high cost of R&D and various clinical trials, they can be painted by the state and the public not as a revolutionary innovators, but rather a bunch of "greedy capitalists" who do not understand the urgency of "patients over patents".

One impact of this government practice is that the patentee/s and drug innovator/s can lose money, so the latter will try to recoup extra revenues from their other drugs, which will affect the patients buying the price-pushed drugs. There can be drug price hikes across the board (Stevens, 2007).

If those innovator companies cannot do this because of other forms of regulations like price control, one option for them can be to stop producing innovative drugs against evolving diseases, just continue producing existing off-patent drugs and spend more money on advertising and corporate sponsorships, hire more attractive and articulate medical representatives and salespeople. Then they can rechannel their high-tech R&D capacity to produce innovative drugs for muscle or breast enlargers, skin whiteners, fat burners, libido enhancers, other drugs for cosmetics and dental surgery. Or perhaps launch a new shampoo, new toothpaste, new mouthwash gargle, and so on.

V. Price control, Mandatory sale, Mandatory production of generics by patentees

(1) Drug price control will result in ever-higher drug prices

Price control empowers the issuer of that privilege to determine and dictate which products are "more useful" to people and which prices of these products should be allowed and which ones should be controlled. But price control cannot lead to lower commodity price and good health.

The usual suspects why medicine prices are high – the pharmaceutical companies' high profits and their high advertising costs, not high and multiple taxes, high cost of R&D in medicine innovation, related costs – are often over-stated. When prices are controlled,

producers who can possibly make some “miracle” products and medicines at sky-high costs will be discouraged from innovating and producing those products. In the absence of more effective drugs to evolving diseases, patients and their physicians will resort to take measures that are more costly, like longer hospital stay and even surgery.

It is unfair when government puts up uncontrolled taxes and fees, uncontrolled regulations, then control the price of commodities later. What can rein in prices is more competition among manufacturers and sellers, not more bureaucracies. Besides, the “ceiling price” set by a government price regulatory body is usually based at prices for older technologies, not the latest medicines and therapies that produce better health result for the patient.

Better allow price segmentation – different prices for different products or services for different people. This way, people from different economic status can be served. Poorer patients can have cheaper medicines, say anti-biotics to cure viral infection, and recover in 1 to 2 weeks. Middle class patients can have medium-priced medicines for the same disease and recover in 1 week or less. While richer patients can have expensive medicines but they can recover in 1 to 2 days. The drug manufacturer makes big profit from more powerful but more expensive medicines consumed by richer patients, so that it can sell less powerful but nonetheless safe, effective and cheaper drugs to poorer patients.

”Price abuse” by certain companies is definitely a possibility if the economy is not competitive enough and if there is no level playing field. If a country allows only a few, say a dozen, innovator companies to operate by virtue of dozens upon dozens of regulations and restrictions, and there are hundreds of copy-caters, then that country can be at the mercy of the few innovators who decided to hang on.

Finally, if the Secretary of the Health Department and/or the President of the Republic are corrupt, they can easily go to the big pharmaceutical companies and say, “Hey, we will put your best-selling medicines under price control… unless you pay us.” This possibility is not remote considering the bad governance culture in many developing countries.

(2) Mandatory sale and distribution of parallel imported drugs

As discussed above, there may be some problem with parallel imports because the importers are not the same as the manufacturers and patentees who have direct accountability for the quality of their newly-introduced medicines. Should a new product produce some adverse results to patients, product recall is expected and the patentees can shoulder this cost not only because they have already earned a good profit from selling a new and high-priced medicine, but also because it’s their trademark, their brand name that will be endangered if they will not do something for their defective product/s.

Private drug stores and pharmacies can be put in an awkward position if they will be forced to sell drugs that may come from dubious sources and manufacturers. The right of traders and private enterprises of what products and services they will provide and sell, and which ones they will not provide or sell, is a basic civil right. Thus, the mandatory sale of parallel imported drugs by private drugstores is wrong. The state can sell those parallel imported drugs through its thousands of "People's pharmacy" because it is the one that pushed that scheme in the first place.

(3) Mandatory production and distribution of generic counterparts by manufacturers of branded products

While the goal of achieving cheaper prices is commendable, this coercive measure is not. As explained above, not all branded medicines will be making money since the big costs in developing them would prevent them from being sold at very low price, which can turn off many customers. Inventors and innovators should be allowed to make "monopoly profit" from their new products because they have "monopolized the big cost" for a decade or more while the new medicine was undergoing several clinical trials and various R&D processes.

Thus, coercing manufacturers to produce generic counterparts of their branded drugs is not correct. Let other manufacturers come in and produce their own generic drugs with their own brands. The main purpose of branding is to directly associate accountability of the products with their manufacturers. Hence, reputable manufacturers should produce safe and reputable products; otherwise, if they produce defective products and they do not recall and replace these with safe ones, they will lose their reputation and pretty soon, their customers.

Meanwhile, it was good that the earlier provision in the House version to require physicians to prescribe "generics only, no branded drugs" was shot down and dropped. Forcing physicians that they cannot prescribe a particular brand out of several dozens, if not hundreds, of different brands in the same generic category, will be another violation of the people's civil rights.

Under that scheme, doctors will prescribe "generics only", and there are stiff penalties for violating this. So that patients will have to ask the non-physicians, could even be non-pharmacists, in the drug stores or super-markets or convenience stores that sell medicines, which of several drugs in the same generic category is the cheapest. It looks cute, except that it could be risky for the patients. Physicians and pharmacists observe that different brands under one generic category are capable of causing different effects, delayed effects, or allergic reactions to different patients. Besides, if the purpose of that provision is to kill the practice of "pharmaceutical companies bribing physicians for product endorsements", then that provision can possibly result in "pharmaceutical companies bribing pharmacists and drug store owners for product endorsements".

VI. Alternative schemes to lower medicine prices

Since the above provisions will not likely result in making available effective medicines and their price to drop significantly, below are some proposals that can fill the gap in attaining an "affordable quality medicines" objective:

1. Reduce if not abolish taxes on medicines

At present, medicines are slapped with at least (a) import tax of 5 percent and (b) value added tax of 12 percent. In addition, companies that manufacture and distribute medicines are slapped with 35 percent corporate income tax, another 12 percent VAT on office rentals, various documentary stamp taxes, other fees. If these taxes are drastically cut by half at least, then medicine prices can immediately go down, so we will have cheaper quality medicines.

Aside from import tax/duties and VAT, other indirect taxes and fees on medicines that are applied at least in other countries are port charge, inspection fee and pharmacy board fee. The total burden of combined taxes, charges and fees slapped on medicines, as a percent of retail medicine prices, can be as high as 55 percent (India), to 34 percent (Nigeria), 33 percent (Pakistan), 29 percent (Bangladesh), 28 percent (China), to 24 percent (Mexico). [See "Increasing access to medicines" by Ahmad, Cudjoe, Davie, Krause, Mitra, Oplas, et al, in Stevens, editor, Fighting the Diseases of Poverty, 2007]

The state and the officials who run and administer it, including the legislators that created or retain the current taxes, should also bear their share of sacrifice if they are indeed sincere in having cheaper or affordable quality medicines to the people whom they promise to serve.

2. Reduce regulations that discourage the entry of more reliable pharmaceutical companies from other countries

Currently, there are about 45 multinational pharmaceutical companies in the country. But not all of them are competing in each product category. For instance, some companies do not have pediatric products, so they do not compete with other pharmaceutical firms that sell medicines for babies and children. So that it is possible that for some diseases, there are only 2 or 3 manufacturers competing to produce the drugs for such diseases.

One time-proven mechanism to reduce the price of something is to have as many producers and innovators of good quality products and let them compete with each other.

Let us have more competition among many innovators, not between a few innovators and many copycat-ers. Unfortunately, the new law may result in discouraging the entry of more innovator companies, and instead attract more generics companies that do not engage in expensive and time-consuming R&D.

If existing government regulations – from local governments to the BIR and DTI to BFAD and DOH – are relaxed, plus proposed measures that weaken IPR for their products and innovation are shelved, then there should be more multinational pharma companies that can come in and pose additional competition to the incumbent firms here.
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In addition, it will also be a better alternative to parallel importation. If the (a) foreign manufacturer, (b) foreign wholesaler, (c) importer, and (d) local patentee, are the same, then identifying who will be accountable in cases of ineffective or unsafe and counterfeit drugs will be clearer and easier.

It is also good that a proposal by some groups and individuals to establish a state-owned pharmaceutical company, like Thailand's Government Pharmaceutical Office (GPO), or a proposal to "nationalize" the local pharmaceutical industry, were not considered, although the provisions on "government use" and compulsory licensing is the closest thing to this proposal. Because using the market to drive investment will be efficient in providing the most drugs at the most sustainable prices to the people who most need them. Market-driven investment, whether in pharmaceutical multinational companies or partnership with local production enterprises, helps countries realize Ricardian gains from trade (Bate, 2008).

3. Free trade, not parallel importation

One ugly government intervention in health care is trade protectionism. The 5 percent import tax on medicines is one proof of such protectionism. If we want cheaper medicines, we should have free trade – zero tariff and non-tariff barriers – and allow plenty of reliable pharmaceutical companies to come into the country. They will bring their medicines from Europe, US, Singapore, India, Pakistan, and other countries, and let them compete among themselves. But dismantling of trade protectionism in medicines was not considered in the soon-to-be cheaper medicines law. What was highlighted there was parallel importation.

Parallel importation is not equivalent to free trade. The former is allowing non-patent holders and "copycat-ers" to import medicines that are locally-patented without the permission of the local patentees. Free trade is allowing plenty of medicine manufacturers, especially medicine innovators, who are patent holders to bring in their innovative and patented medicines and products, and they compete among each other here both in quality and price.

Under parallel importation, the State can practice double standards: it creates bureaucracies, and collects taxes and fees to domestic-based pharmaceutical companies that applied for patent and IPR, then turns its back and disrespect the same patent that it granted by allowing parallel imports, then further collect taxes and fees from importers and retailers.

On the other hand, free trade has only one goal: give consumers more choices. The State need not practice double standards to achieve this. If it wants to implement the patent system and protect IPR, then all importers should be patent holders. If there are not enough patent holders and local players, then allow more players from more countries to come in. And they will come in if there is enough profit to make, meaning operational costs – like taxes, regulatory fees, and other compliance costs – are low and simple to follow.

VII. Related Public Health Issues

When a person is sick, he would not normally buy a medicine instantly. He would first see a doctor, and the doctor would not immediately prescribe a particular medicine, but sometimes instruct the patient to undergo certain physical check-up to find out any hidden diseases behind the symptoms experienced by the patient. So what often harms the pockets of patients is not medicine prices, but the cost of diagnostic tests, clinic or hospital stay, and physicians' and other health professional fees, especially if one goes through surgery.

After the diagnostic tests are done, usually a patient can get well not so much with regularly taking expensive medicines, but with a more healthy lifestyle, good rest and avoidance of certain "undesirable" food and drinks (as specified by the physician) that can trigger allergies or resurgence of the disease and its symptoms. Below are some issues that affect public health.

1. Undeveloped health insurance sector

Private health maintenance organizations (HMOs) address this concern by patients. For a fixed annual fee, a person can have annual medical check-up even if he is not sick. And if he gets sick, he can visit a physician, undergo laboratory or X-ray or other diagnostic tests, stay in a hospital if necessary. If the total cost of all these exceed the maximum exposure by the HMO, that's the time that the patient will pay extra out-of-pocket expenses. Just having a health insurance with an HMO already gives peace of mind to people, sickly or otherwise, in case they will encounter some health problems.

There are not too many private HMOs in the Philippines. Various government regulations and taxation should be part of the reasons why the market is not fully tapped yet.

Government's Philippine Health Insurance Corporation (PhilHealth) is too colored with political intervention and corruption charges, rendering it inefficient to serve the needs of many people. That is why people and companies with extra resources, would rather enroll themselves and their staff in private HMOs for quick and more efficient medical health services.

2. Diseases related to poverty

Many people get sick not because they cannot afford "expensive" medicines and hospital care but because their drinking water is dirty, their neighborhood is mosquito-infested and unsanitary, and their schools and offices are exposed to high pollution and dirty air. These are called "diseases of poverty", and medicines and hospitalization, even if they are provided free, become palliatives.

The solution here is economic freedom, economic prosperity, then people can live in clean and healthy neighborhood, drink clean water, not exposed to heavy pollution communities.

Of course people can get various sickness and diseases due to personal irresponsibility. Like being drunkards, heavy smokers, taking addictive drugs and smokes, over-working and over-partying and have less rest, engaging in unprotected and promiscuous sex, and so on. For this type of behavior, being self-inflicted, other people's money (ie, taxes and various compulsory fees) should not be touched or confiscated to subsidize the medicines and hospitalization of the affected people.

VIII. Conclusion

One important scheme to attain a "cheaper quality medicines" environment is to expand the supply of innovative and effective medicines, even if they are initially expensive. Something like instead of a medicine that can remove a patient's viral infection (and the pain) in 1 to 2 weeks, go for a medicine that can do the same job in just 4 days or less. So one obvious solution is to expand the number of innovator companies, whether local or multinational, and let them compete with each other in giving us more effective medicines. It is competition, not over-regulation and high taxation (as done by many governments) that can bring down the price of anything. Customers can mark those who sell expensive products relative to their quality, those who sell bad quality products, especially unsafe and fatal products in the case of counterfeit medicines. Sellers and providers would naturally aspire to sell only good quality and safe products, even if some of those goods have to be sold at higher prices, and gain customer support and patronage.

Medicine innovation should be encouraged to come in if we want newer, more effective medicines, to fight evolving diseases in our evolving communities and evolving

environment. Innovative medicines are not cheap, with an average industry cost of around US$1 billion just to develop one good medicine. Copycat medicines are always cheap because the "copycat-ers" never spent a single centavo on medical research and development; they only have to spend on glitzy marketing strategies and sales people.

The emergence of more private HMOs, more private hospitals and clinics, competing for patients and clients while building and/or preserving their corporate brand and reputation, is an important aspect in improving public health care.

Ironically though, it seems that society can achieve the above goal of encouraging plenty of innovator and healthcare companies if there is less government intervention, over-regulation and taxation.

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