Essays on IPR and Health, Part 3

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The following are my recent articles and short papers on the subject of intellectual property rights (IPR) and public health. The first two are my columns in the online magazine, www.thelobbyist.biz, while the last four are my short blog postings in http://funwithgovernment.blogspot.com/

(1) Cheaper health care through less regulation

9 January 2009
http://www.thelobbyist.biz/column_detail.php?id_article=1045&id_category=25

The cold weather the past two months induced by a cold front has caused various illnesses to many people including this writer who was knocked down by a bad cough. Even some crops and farm animals were adversely affected by the cold weather.

I saw a doctor through my health maintenance organization (HMO). After a routine check-up, my doctor prescribed some antibiotics and adviced me to take plenty of fluids. I got well. After a few weeks, partly due to some late night Christmas parties and reunions I attended and the persistent cold wind, my cough came back.

The other doctor in the same HMO suspected there could be something wrong because my cough came back in a matter of weeks. So he requested for a chest X-ray; he did not prescribe any medicine but advised me to take more water and juice and wait for the result. When I went back to him after a few days with the X-ray result (which said my lungs were clear), my cough has subsided. He said that I should continue drinking lots of fluid, no medicine, go home and get more rest. I got well.

And this leads us to at least three important points.

One, when a person is sick, the first thing that he would do is to see a physician, not buy any medicine. After the initial check up, the physician may not even prescribe a medicine yet and request for some diagnostic tests (blood test, urine test, x-ray, etc.), wait for the result, before prescribing (if necessary) any medicine.

Two, it is important to get a private HMO (many companies here do this). Physician visits, certain diagnostic tests and hospital stay when necessary, are covered. This gives some peace of mind to people. For many poor people who do not have health insurance when they get sick, the first thing they do is to self-medicate: go for some herbal products, buy the "usual" and cheap medicines, and see a doctor only when the pain gets worse, perhaps because they bought counterfeit medicines or took medicines that were inappropriate or could trigger some side effects to their other diseases.

Three, competition among private HMOs make their services to their clients more efficient and fast. What often harms the pockets of patients is not medicine prices, but the cost of diagnostic tests, clinic or hospital stay, and the physicians' and other health professional fees, especially if one goes through surgery.

So if diagnostic tests, physicians' fees, hospital stay are among the expensive aspects of public health care, do we expect new laws and government regulations like "Cheaper diagnostic tests law", "Cheaper physician fees law", "Cheaper hospital stay law", along the lines of the recently-enacted "Cheaper medicines law"? Will we see price control in diagnostic tests, physician fees and hospital stay, the same way that the government enacted medicine price control? And will we see the retention of VAT, import tax, import documentary stamp tax and other taxes on hospital/clinic laboratory and medical equipment, high corporate and personal income taxes on hospital and health professionals' income, the same way that the government retained those multiple taxes on medicines while pontificating that it wants "cheaper medicines"?

The HMO sector should be spared from current and future attempts at more government regulations. Regulations by nature mean prohibitions. They are meant to create paralysis, even temporarily. Government regulators say, "Don't move, don't start anything, until you pay various taxes and fees, until you get our signatures and permits first."

There are not many private HMOs in the Philippines. Private HMOs are non-mandatory, which force these private companies to deliver efficient services at more affordable costs to attract more clients. The Philippine government's health insurance monopoly, PhilHealth, is mandatory and corporate membership and registration is done by force. And since it is a political institution created by law and funded by mandatory -- not voluntary, contributions, we would hear lots of political intervention, inefficiencies, even corruption charges.
A monopolist with guaranteed income from forced contributions can afford to be lazy and inefficient since there is very little possibility of losses. And should huge losses show up later, there is no possibility of bankruptcy because there are always billions of pesos of tax money to bail it out.

The medicine sub-sector of Philippine health care system has been lost to huge government intervention and regulations. From patent confiscation (through compulsory licensing, government use and parallel importation) to medicine price control, to generics only for government physicians plus many other provisions, the extent of government intervention is wide.

It is important therefore that the other sub-sectors of the country's health care system should be spared from further government encroachment and heavy regulations. These sub-sectors include the HMOs, hospital and clinic expansion and branching, and medical education. Protection of the public is best assured by competition among players and brand or corporate integrity, not more government taxation, regulation and sometimes, cronyism.

(2) Medicines Transparency

23 January 2009

http://www.thelobbyist.biz/column_detail.php?id_article=1055&id_category=25

This week, the Medicines Transparency Alliance (MeTA) held a one-week activity in Manila. Last Monday and Tuesday was a workshop for local civil society organizations (CSOs) engaged in health, consumer protection, government procurement and policy. I was invited in this event to represent our think tank, Minimal Government Thinkners, Inc. The next three days, Wednesday to Friday, was the MeTA 2nd National Forum, attended by various sectors and groups, from government to pharmaceutical companies, professional organizations to CSOs.

MeTA is an international alliance of various stakeholders pushing for greater access of more people around the world to essential medicines by improving transparency and accountability. Its international secretariat, funded by the UK government, then the World Bank, World Health Organization (WHO), various governments, some pharmaceutical companies and big international CSOs, is helping the formation of country "branches", like MeTA Philippines.

The 3-days forum tackled lots of interesting topics and issues. For lack of space, this paper will discuss only four of them: (1) lack of health insurance, self-medication by people, drug advertising; (2) local government medicines warehousing, (3) taxes and fees on medicines, and (4) IPR confiscation of innovator drugs. A short discussion of my respective proposals for these issues also follow.

First, the lack of health insurance by many people, especially private health maintenance organizations (HMOs), forces them to self-medicate when they get sick. A visit to government hospitals and physicians (either free or low fees) means long queu, while a visit to private physicians and clinics means high costs in physicians'

fee and possibly diagnostic tests. So to cut costs or avoid long queuing, people self-medicate and buy medicines that are most popular, as advertised in tv, radio, newspapers and outdoor billboards. Pharmaceutical companies know this, so some of them spend a lot of money on advertising, which leads to higher medicine prices, aside from possibly exaggerating claims of beneficial power of their medicines.

My thought on this is that the HMO sub-sector should be deregulated by the government, attract more companies, local and multinationals, to come and provide additional competition in the field, so that various income brackets can be served. For instance, richer people and subscribers can pay P20,000 per year or higher for wider health coverage, middle class people can get P6,000 to P15,000 per year, others can charge P1,000 to P5,000 per year for narrower health coverage (say maximum P20,000 hospital bill in one year, X number of free physician visits, Y set of free diagnostic tests, and so on. The important point is that even poor people can get health insurance on top of their PhilHealth membership to encourage them to see a health professional first before they buy any medicine. This will also neutralize any untruthful claims by heavy drug advertising as patients will listen more to their physicians, not to advertisers.

Second, medicine storage and warehousing by local governments for their constituents. A presenter from the WB showed some of his findings, complete with pictures: dirty warehouses, rodents, garbage and medicines mix up in one room. Warehouse personnel who do not make a regular inventory of medicines, how many have been disposed, how many are left, how many and what drugs are expired. Warehouses that do not have temperature control; one warehouse has a thermometer, fine, but the room temperature is several degrees hotter than the required minimum temperature for proper storage of some medicines. Some local health personnel release and give away expired drugs.

My proposal on this is that those warehouses by local government units (LGUs) should be closed down, LGUs can issue vouchers to their poor and needy constituents, the latter will go to government-accredited *Botika ng Bayan* or *Botika ng Barangay* to get the medicines, and the LGUs will pay those drug outlets later. There will be no need for LGUs and DOH then to train personnel for medicine procurement, warehousing, storage and inventory as internally proposed (using WB loans or additional budget appropriations) as these skills are already available in those government-accredited drug outlets. The comparative advantage of LGUs is politics and more politics, not efficient health care provision.

Third, taxation of medicines, apart from taxation of firms dealing with medicines manufacturing, marketing, distribution and retailing, remains high. Among these taxes are: import tax, documentary stamp tax, municipal or city tax, value added tax (VAT). Industry estimates put those various taxes at around 20 percent of the retail price. This means that the government, national and local, is responsible for expensive medicines

by around 20 percent. And yet the government is “championing” cheaper medicines? This is pure irony, if not hypocrisy.

Removal of many taxes on medicines is definitely one sure way to bring down the price of this essential commodity. And this will require amending the law on National Internal Revenue Code. I proposed during the open forum that MeTA Philippines can possibly spearhead this measure and the affiliated stakeholders can back them. Our think tank will definitely support MeTA or whoever will spearhead this move.

Fourth, local pharmaceutical industry figures show that only 10 percent of all medicines in the country are patented, 90 percent are already off-patent. If we are to follow the logic, “patented = expensive” and “off-patent = cheap” medicines, then we are supposed to be expecting only 10 percent of all medicines to become cheap as a result of intellectual property rights (IPR) confiscation provisions in the “Cheaper Medicines Law” via (a) international exhaustion and parallel importation, (b) government use, (c) compulsory licensing), and (d) early working principle. The World Health Organization (WHO) even has a more dramatic figure: only one percent of all essential medicines in the world are still patented, 99 percent are off-patent. So the fuss on “patented = expensive, non-accessible to the poor” logic does not hold water, because 99 percent of all medicines in the world should be cheaply available and accessible to the poor.

My proposal on this is nothing. Said provisions are now legal, have implementing rules, they only need to be implemented strictly. I only have a short advice to some groups who strongly supported those IPR confiscatory provisions: that they admit that their advocacies are driven mainly by envy, by lack of appreciation of the need for continuing medicine innovation, by hatred of multinationals, even hatred of global capitalism.

Blog Postings, http://funwithgovernment.blogspot.com/

(3) Pfizer-Wyeth merger and medicine innovation

January 28, 2009

The Pfizer-Wyeth merger, ie, the former bought the latter at $68 billion tag, is seen by some groups as "moving towards oligopoly" of the world pharmaceutical industry. That it's like approaching "Big Oil" or "Big Tobacco".

I think business moves like this merger should be considered as purely micro- and corporate decisions, as such mergers were done voluntarily: one proposed to buy, the other agreed to be bought, at a certain price and other agreements.

As consumers and patients, our main concern is whether medicine innovation and competition among players for innovator medicines, is retained and expanded, or compromised and scuttled, as a result of this merger. This is because there is ample supply and competition among players in the generics drugs market in the country and many parts of the world. It is in the innovator medicines where problems are cropping up, and ironically, at the time where people are getting more demanding, more impatient, for more “miracle drugs” that can treat their various diseases quickly and safely.

The Pfizer-Wyeth joint statement said that the merger will result in more “synergy” between the research capability and output of the two companies, enabling the single entity to produce more output at lesser cost. Technically this will result in cheaper price of innovator medicines, unless external distortions like multiple taxes and fees and health regulations will also rise, which can erase and neutralize the gains in corporate synergy and efficiency.

The "cheap at all cost" and "access for all" medicines mantra is all around the world now. Understandably in poorer countries, but in rich and industrialized countries like the US, this seems to be ironic.

There is also another irony for many health bureaucracies around the world, like Department or Ministry of Health in many governments, and the WHO: there is huge if not panicky focus on "access to cheap medicines for all" that often result in discouraging medicines innovation, but these agencies are also highlighting "emerging and re-emerging diseases" that need medicine innovations. In the Philppines for instance, the DOH is watching ebola, new avian flu virus, etc. and hinted at the need for "new medicines".

This irony is posing danger to humanity. My observation though is that if you create enough "noise" at the DOH- or WHO-sponsored or co-sponsored fora, they tend to listen. Some sanity should emerge later, when they finally realize the long-term risks of their interventionism and anti-innovation policies.

(4) Innovation, price segmentation and medicine access

February 1, 2009

There is one big difference between analysts from government health ministries or departments, WHO, WB, UN, other foreign aid or tax-funded agencies, and those from private, free market think tanks: The former do not put strong emphasis, if any, medicines and other health innovation, Everything for them is access and affordability. Once you solve the problems of access and affordability to the poor, many other solutions will follow.

If medicine and healthcare (or any other sector) innovation is left unharrassed and

unburdened with super-strict regulations and IPR confiscation, price and product competition, and price and product segmentation or differentiation, will follow. This is because as medicine innovators produce more powerful, more revolutionary and more effective and safe medicines, they will be forced to sell the less powerful and predecessor medicines at a discount, to capture the bigger and plentier markets and consumers at very low profit margins, and capture the smaller but richer consumers at very high profit margins via the new and more powerful medicines. This way, access by the poor, affordability for the poor, is addressed, while desire by the richer segments of society for more powerful medicines, even at very high prices (our personal health is priceless, right?), wil also be addressed.

Economists from the WHO, the Center for Global Development (CGD), other institutions are bright people with PhDs. They understand perfectly the role of price segmentation and price differentiation in addressing supply problems in various sets or sections of consumers. But since they are indebted to politicians who appropriate and allocate them with tax money, they can somehow fall into health politicization, if not health socialism, perspective, by the politicians and funding governments.

(5) China's new patent law and CL

February 10, 2009

Ronald Cass, Dean Emeritus of Boston University School of Law, and President of Cass and Associates, has a good article in the Wall Street Journal yesterday, "Patent Reform with Chinese Characteristics". The focus of his paper is China's recent Third Amendment to the patent law, which provides for, among others:

1. Encourage innovation in China and protect genuine inventiveness, such as increased protections for innovations created by cross-border research efforts.

2. Adoption of an “absolute novelty” standard, stop patent grants to Chinese applicants who were effectively “hijacking” inventions from abroad.

3. Provision for compulsory licensing (CL) by the State, without the approval of the patent holder, to anyone who is able to produce the product once given access to the patented technology.

Ron Cass noted that while the first two are positive development, the 3rd is not. And rightly so. The term "compulsory" already implies mandatory, coercive action by the State to get or appropriate a license or any form of privately-owned property. This immediately results in violation of private property rights and promulgation of the rule of law. These two principles, private property and rule of law, are the strongest mechanisms by which freedom by individuals and private enterprises, are respected and innovation is encouraged.

There are some similarities between the Philippines' new "cheaper medicines law" and

China's third amendment, in the conditions by which a CL can be issued by the state -- national emergencies, anti-competitive behavior by the patent holder, etc. There could be an "Asian wave" of popularizing CL by Asian governments: Thailand, Philippines, China, also India? Other Asian countries may not be far behind.

Meanwhile, I read yesterday in Business Mirror here in Manila, a news item, "Novartis picks RP as Asia research hub". This seems to be a brave move by Novartis considering that the "cheaper medicines law" is very bias against popular innovator drugs, and very lenient on generics drugs sale and manufacturing.

Novartis' research center will open by June this year, doing research and manufacturing for both generics and innovator drugs. Maybe their focus will be more on generics, considering the above discussions.

(6) Biomedical research does not need fiscal stimulus

February 11, 2009

There's an article from thescientist.com the other day forwarded by a friend, entitled "Biomedical research is ripe for a stimulus" written by Garret FitzGerald. The author is the Director of the Institute for Translational Medicine and Therapeutics at the University of Pennsylvania, and serves on the Peer Review Advisory Committee of the NIH and the Science Board of the FDA.

http://www.the-scientist.com/templates/trackable/display/news.jsp?type=news&o_url=news/display/55405&id=55405

In his paper, Mr. FitzGerald is clapping the injection of taxpayers' money, aka fiscal stimulus, to the biomedical research sector through the following mechanisms, among others:

1. Restore funding for the National Institutes of Health (NIH). The new director must have resources to fuel innovation by individual investigators and invest in infrastructure.

2. Integrate the disparate missions of the NIH and the Department of Health and Human Services -- particularly its Agency for Healthcare Research and Quality and the Food and Drug Administration (FDA).

3. Reward innovation and foster the progressive personalization of medicine. Fund programs that foster interaction of the FDA with academia.

This is one of many statist literatures that circulate in praise of more fiscal stimulus, more government borrowings and subsidies, and indirectly, more taxation in the future.

Expansion of NIH, government – not the consumers and the public – rewarding innovation, more funds for FDA and the academe.

I thought it's the consumers and patients, the physicians and other health professionals, who determine who among the many pharmaceutical and biotechnology companies, are the most innovative, the ones who produced the most effective and most useful medicines and other health products. Now it is the government officials who will determine who and what are the most innovative companies and products.

People value their health a lot. That is why many of them are very careful with their body, while a few are very irresponsible with their body and yet very vocal in demanding that quality health care is their "basic right". For the responsible people, they would wish that personal income and other taxes are lower so that they can save more, and they can invest more for their persona and family healthcare. And for the responsible and innovator companies, they also wish that corporate income and other taxes are lower so they can have more corporate surplus to pump into more biomedical research and development, and to reward their investors and shareholders who put their money in biomedical and pharmaceutical companies, and not in other industries or sector.

In short, the biomedical sector does not need fiscal stimulus and other forms of government subsidies, if the distortions to personal and corporate endeavors invented by governments are few or absent.