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

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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.

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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

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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).

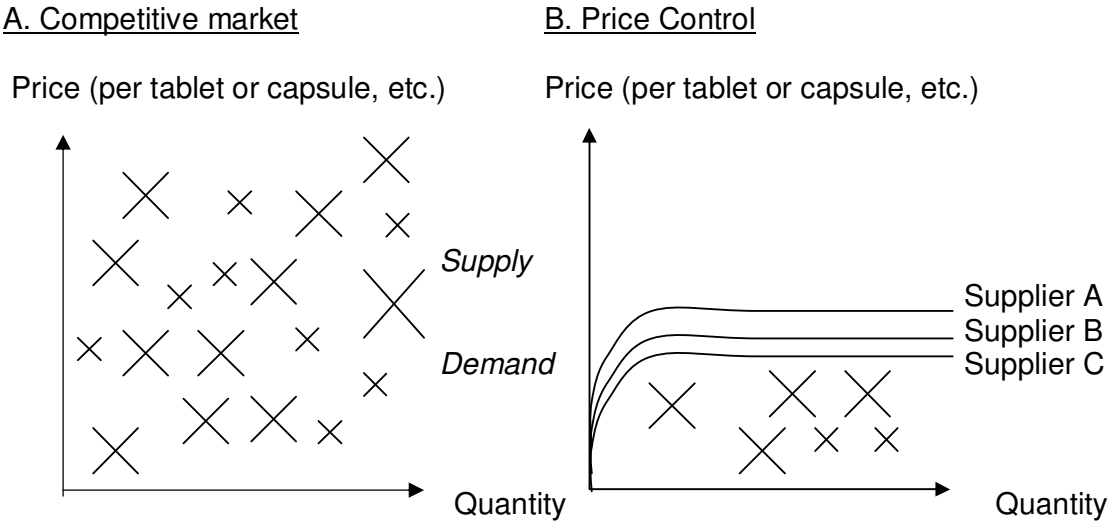
3. Price setting under a competitive market vs. price-controlled market

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



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	Event
June 6, 2008	RA 9502 signed into law by the President of the Philippines
July 4, 2008	RA 9502 became effective
November 4, 2008	Implementing Rules and Regulations (IRR) of RA 9502 signed (a joint product of DOH, DTI, BFAD and IPO)
January 14, March 26, April 27, June 5 and 19, 2009	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 2009	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, 2009	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, 2009	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, 2009	Meeting by leaders of some MPCs in Malacanang, with the President on July 8, regarding the impending EO imposing drug MRP.
July 13, 2009	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, 2009	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, 2009	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, 2009	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, 2009	Start of implementation of both "voluntary" and mandatory price reduction for the big drugstores. Total of 21 molecules, nearly 100 drugs, covered.
Sept. 15, 2009	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 (4^{th}) 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 covered 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.

<u>d. Hospitals</u>. 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	GOVT-MEDIATED ACCESS (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
Cyclophosphamide	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)	100 mg tablet	Qualimed	1130.00	565
Mercaptopurine	50 mg tablet	GSK	79	39.5
Methotrexate sodium (No innovator locally)	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 + Atorvastatin calcium 80 mg tablet	91.79
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 25 mg/5mL	**Pharma Link Asia Pacific**	**264.75**	**211.80 (20%)**
	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**

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

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