Property Right and Pricing Left Under the Cheaper Medicines Law [1]

Bienvenido Oplas, Jr. [2]

Abstract

Property rights of drug innovator companies so far have been generally respected under the Cheaper Medicines Law. Pricing left though, or taking drug pricing towards a left-leaning policy of price control, has compromised some energy and resources of the health agencies of the government as results of the more than six months old drug price control policy did not produce clear and explicit positive outcomes. Other policies that still advance the spirit and intent of the Cheaper Medicines Law need to be explored instead. Two economic tools were employed in analyzing the policy, namely pricing under free market and under government control, and game theory. The relationship between political risks and R&D spending on HIV prevention is also discussed. The paper argues that improving the business environment by respecting competitive pricing will attract more players and competitors in the healthcare sector, that this should be prioritized rather than demonizing the existing players. And that healthcare is mainly personal and parental responsibility, government to provide secondary responsibility on a few and targeted groups.

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

[2] President, Minimal Government Thinkers, Inc. Email: minimalgovernment@gmail.com
Author acknowledges the travel grant to Cebu given by the Coalition for Health Advocacy and Transparency (CHAT). CHAT is the civil society partner of Medicines Transparency Alliance (MeTA) Philippines, and is composed of various health NGOs and independent research institutes like MG Thinkers.

Property Right and Pricing Left Under the Cheaper Medicines Law

Bienvenido Oplas, Jr.

1. Introduction

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

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

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

Another big debate then was whether physicians should be banned or not, from writing the brand of medicines in their prescriptions to their patients. Later the physicians threatened a "physicians' or hospital holiday" as a form of protest to the proposal in the bill to disallow them from prescribing a certain brand to their patients, and to prescribe just the generic name of medicines. The legislators relented on this action by the physicians. In the implementing rules and regulations (IRR), only physicians from government hospitals and other public outlets are barred from prescribing medicine brands, physicians from private clinics and hospitals can do so.

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

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

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

2. Price control and supply distortion

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

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

Since the audience of this forum are mostly university students, graduate students of health economics more specifically, some theoretical discussion of the subject can be introduced.

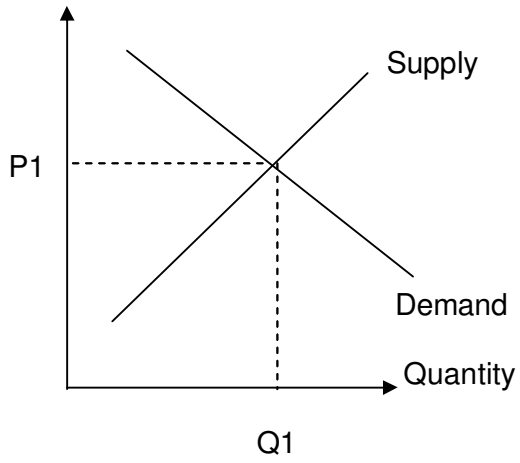
Under free market pricing, supply meets demand at a price that each seller and each buyer agrees. For instance, a vendor sells mangos at P50 a kilo. Buyers A and B agree to the price and they get a kilo or more. Buyer C does not agree and walks away to find another mango vendor who can sell at only P45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

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

Chart 1. Comparison of market and government pricing

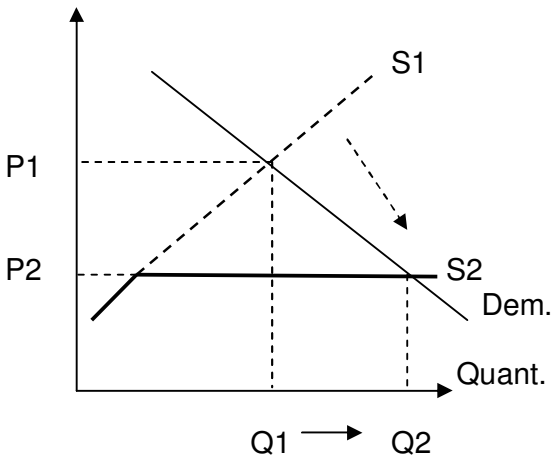
<u>A. Free market pricing</u>

Price (per bottle, per tablet, per liter,…)



B. <u>Government-controlled pricing</u>

Price



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

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

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

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

And finally, the term "voluntary" price cut is not precise because if the manufacturers of those drug molecules that the DOH has identified will not bring down their prices by at least 50 percent, there is a political threat that they will be covered by the Executive Order that the President will issue anyway to force the 50 percent price cut.

3. Actual result of price control

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

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

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

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

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

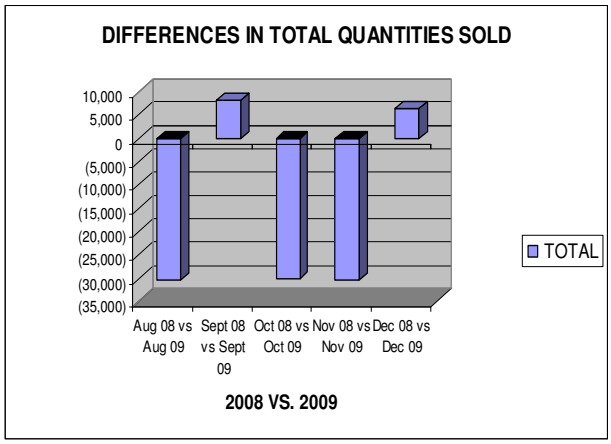
4. Local pharma: We are slugging out with competition with the multinationals and among ourselves prior to price control. We were forced to further bring down our prices. Also, the labeling requirement should be strictly implemented, those under MDRP should have labels in bottles and tablets, "Under price control: Price should not exceed P____" But the DOH is not strictly enforcing that.

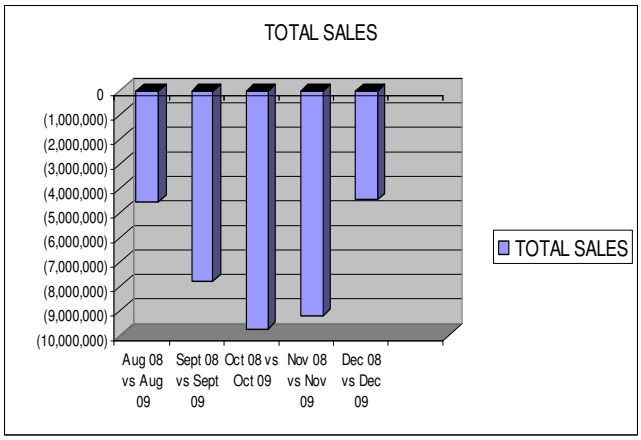
5. Multinational pharma: Sales volume of price-controlled drugs are either stagnant or falling, not rising, which is the target of the law.

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

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

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





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

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

There was another presentation from an industry player during the Advisory Council meeting, where one chart showed there was no significant increase in total sales volume of price-controlled drugs in 2009 compared to 2008. And that among originator or innovator brands in particular, there was no increase in quantities sold,

contrary to expectations that when the price of innovator brands, including patented ones, are forced to go down to only one-half of their original price, there will be increase access by the poor for such drugs. The same can be said for branded generics.

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

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

4. Game Theory

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

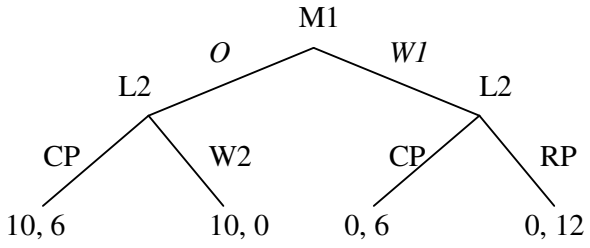
Assume there are two players in a particular drug molecule. Player 1 is a multinational (M1) and player 2 is a local (L2) pharmaceutical company. Before the price control order, M1's price was P20 a tablet and L2's prices was P12 a tablet. That is, L2's prices are 40 percent lower than M1"s.

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

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

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

An extensive form game can be constructed as follows:

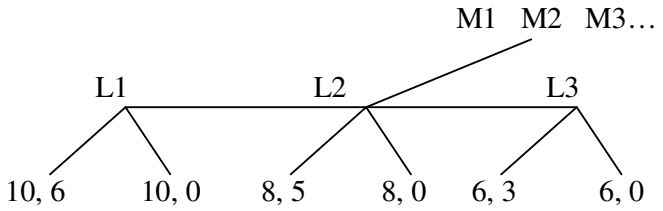


From the data presented above, it seems that the Philippine market went to (10, 6) situation. Very advantageous to the rich and middle class, but disadvantageous to both M1 and L2, and their employees.

The above is only for 2-players game form. But there are plenty of players or pharma companies in each drug molecule category. So we can introduce multinationals 2, 3, (M2, M3) and so on. The same can be said of the local pharma companies, so there are players L2, L3, and so on.

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

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



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

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

For those with sentiments that the price control policy should cause pain and losses to the “profit-hungry capitalist multinationals”, the above exercise in game theory says there is a “law of unintended consequences” and that those who were possibly hurt more, are local pharmaceutical players L1, L2, L3 and so on. Unless the said group of people also wanted to see local companies suffer pain and losses as the multinationals. In which case, their goal may be to see the collapse of capitalism in the pharmaceutical industry and government can begin taking over the industry in the form of drug nationalization.

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

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

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

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

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

* No investment reported

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

The US government has been the main financier of R&D for HIV prevention
- 2004 and 2005, about 77 percent of total global investments (TGI)
- 2006 and 2007, about 68 percent, and
- 2008, 71 percent of TGI

Whereas commercial sector's investment was declining
- 2004 and 2005, about 8 percent of TGI
- 2006 and 2007, about 6 percent, and
- 2008, only 3 percent of TGI

* Same source above.

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

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

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

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

6. On Creating Government Pharma Corporation

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

One way to consider the merit or demerit of such proposal is to look at the food industry. There is no government restaurant, no government carinderia, no government supermarket, and yet people are eating. Compare that situation in the health sector. There are plenty of government hospitals and clinics, plenty of government drugstores, there is government health insurance corporation, there is government price control and related regulations, and health problems are expanding. The main lesson here is clear: where there is bigger government involvement and intervention in sectors that are better left to private players in a competitive environment, endless problems result.

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

7. Concluding Notes

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

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

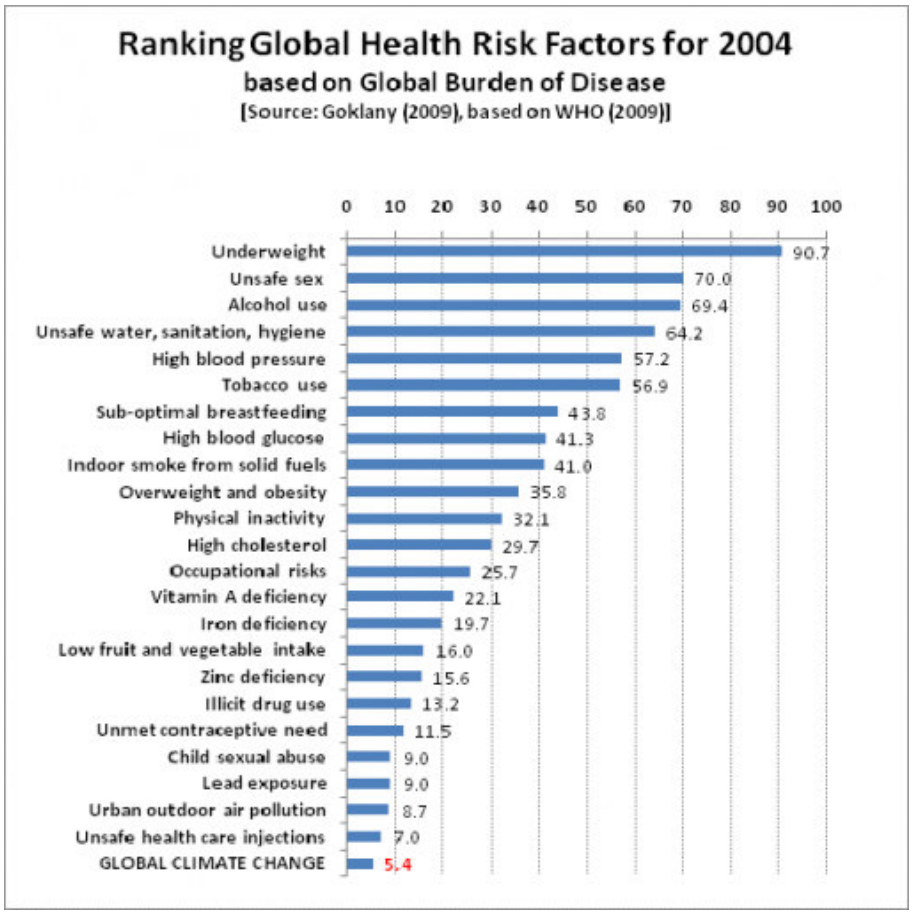
There are other policies though that the DOH and other government agencies, both national and local government units, can undertake that will really address the poor’s deep desire to have access to essential medicines and hence, will still advance the spirit and intent of CML. Like bulk purchasing of certain generic essential medicines and distributing them for free to the really poor patients.

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

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

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

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



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2. "Essays on politicized drug pricing, part 2", December 29, 2009, 25 pages, http://www.minimalgovernment.net/media/mg_20091229.pdf

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6. "Voluntary price reduction vs. mad rush for drug price control", July 17, 2009, 9 pages, http://www.minimalgovernment.net/media/mg_20090717.pdf

B. Other papers

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

Ocampo, Leonila, 2010. MDRP/GMAP: Its Effect on Drugstore Operation (powerpoint presentation).

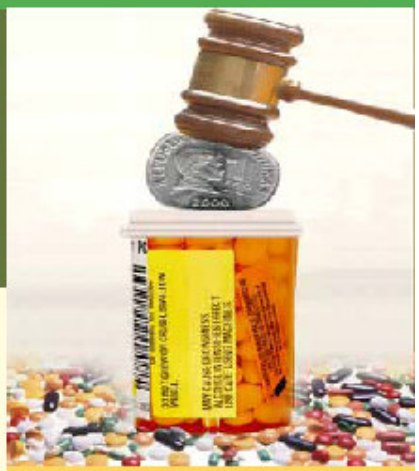
Annex 1. Forum Program

DEPARTMENT OF ECONOMICS

GRADUATE PROGRAM
COLLEGE OF ARTS & SCIENCES
CAROLINIAN ECONOMICS SOCIETY

Science in the Study and Service of Society

The Impact of Republic Act No. 9502 "UNIVERSALLY ACCESSIBLE CHEAPER AND QUALITY MEDICINES ACT OF 2008"



SYNOPSIS

The Department of Health (DOH) mandated a new round of price reductions for at least 97 types of drugs sold in drug stores and hospital pharmacies imposing Maximum Drug Retail Prices (MDRP) to take effect on March 31, 2010. (Philippine Daily Inquirer, February 27, 2010)

In time with this development, this Forum will have speakers from different sectors to discuss their perspectives on RA 9502:

- Government – will discuss the rationale, salient points and a brief summary of the implementing rules of the Act.
- Pharmaceutical Industry Representative – will share their experiences on the impact of the Act on their company's performance.
- Academe – present reactions from the Pharmacy Profession.
- Non-government – will discuss the pros and cons of the Act for the general public.

PROGRAM

Invocation

Philippine National Anthem

USC Hymn

Opening Remarks
Fr. Dionisio M. Miranda, SVD
University President

Rationale of the Activity
Prof. Francisco M. Largo, MA
Chair, Department of Economics

Introduction of the Speakers
Mr. Eduardo Cebedo
MA Economics, 2010

Speaker 1
Dr. Sophia M. Mancao
Medical Specialist III
Department of Health, Region VII

Speaker 2
Mr. Juanito B. Luna
President
Prosel Pharmaceuticals, Inc.
Cebu City

Speaker 3
Prof. Yolanda C. Dellman, MS Pharm
Dean, College of Pharmacy
University of San Carlos

Speaker 4
Bienvenido Oplas, Jr.
President
Minimal Government Thinkers, Inc.
Manila, Philippines

Open Forum

Presentation of Certificates

Closing Remarks
Prof. Francisco M. Largo
Graduate Program Coordinator
Department of Economics

EMCEE
Mr. Hector Olohoy
MA Economics, 2010

Saturday, 06 March 2010
9:00 AM – 11:30 AM

Fr. Theodore Buttenbruch Hall
Main Campus, University of San Carlos

FREE ADMISSION
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Nasipit, Talamban, Cebu City, 6000 Philippines
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Annex 2. Powerpoint presentation

Minimal Government Thinkers, Inc.

Property Right and Pricing Left Under the Cheaper Medicines Law

Bienvenido Oplas, Jr.

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

1. Introduction

RA 9502 or the "Cheaper Medicines Law", enacted in June 2008, covers 6 main subjects to help bring down medicine prices:

(1) Amending the Intellectual Property Code (IPC)

(2) Drugs and medicines price regulation,

(3) Strengthening the Bureau of Food and Drugs (BFAD),

(4) Non-discriminatory clause,

(5) Amending the Generics Act of 1988, and

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1. Introduction

- Before, IPR-related topics like compulsory licensing (CL) and parallel importation were high on public discourses as CL was being used and implemented by the Thai government on some anti-cancer and anti-HIV drugs. Then big debate on the legality of parallel importation and the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property Rights, or TRIPS flexibilities.
- Another big debate then, whether physicians should be banned or not, from writing the brand of medicines in their prescriptions to their patients. Later the physicians threatened a "physicians' or hospital holiday". Legislators relented.
- The debate on imposing drug price control in the bill was generally limited on whether to create a new price control body or not.

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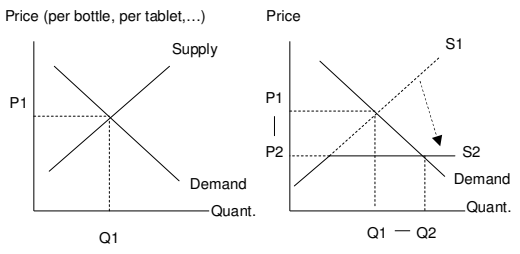

GMAP, MRDP and politics

- "voluntary" price cut 50% under the government-mediated access price (GMAP). GMAP also means Gloria Macapagal Arroyo Price.
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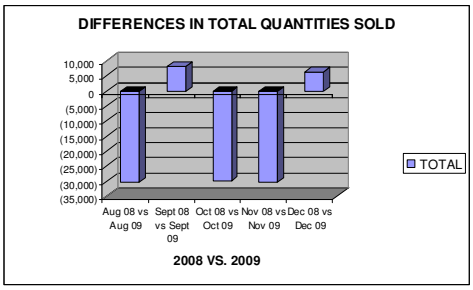
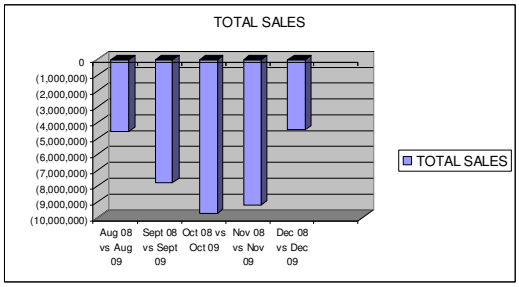
4. Local pharma: We are slugging out with competition with the multinationals and among ourselves prior to price control. We were forced to further bring down our prices. Also, the labeling requirement should be strictly implemented, those under MDRP should have labels in bottles and tablets, "Under price control: Price should not exceed P____" But the DOH is not strictly enforcing that.
5. Multinational pharma: Sales volume of price-controlled drugs are either stagnant or falling, not rising, which is the target of the law.
6. Patient groups: DOH posters in many drugstores that specify the drugs under price control are absent or not visible to the public.

Manson/Med Express drugstore



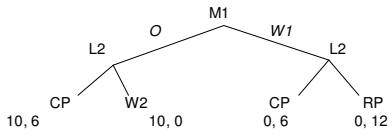
Average decline: -3.4 percent

Manson/Med Express drugstore



Average decline: -34.3 percent

4. Game theory



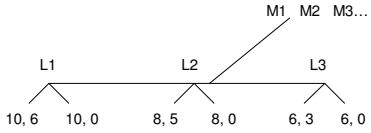
Where: M1 is multinational player, L2 is local pharma player,

M1 orig. price was P20, forced to P10. L2 orig. price was P12, cut to P6.

O is obey the price control, W1 is M1 withrawing the affected product

CP is to cut price further, W2 is L2 withrawing the affected product, RP is L2 retaining its price

Extended left-hand side (right side or product withrawal by Ms did not happen)



Where: M1, M2, M3 are multinational players 1, 2, 3,…

L1, L2, L3, are local pharma players 1, 2, 3,…

Implication: "Law of unintended consequences" happened. The local players were probably hurt more than the multinationals as the locals were forced to further price cut to their already cheap drug prices.

5. Politics and R&D Disincentives

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

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

* No investment reported

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

US government as main financier of R&D for HIV prevention

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

Whereas commercial sector's investment is declining

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

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

Pharma and Biotech companies have the expertise in vaccine development and commercialization. Almost all vaccines used globally today come from them.

Yet, why is private sector R&D investment in anti-HIV small and now declining? 2 factors:

- Political risks: Political risks: threats of compulsory licensing (CL). A successful HIV vaccine developer may be prevented from charging enough to recoup its investments. Plus governments' decisions to implement large-scale vaccination program is volatile.
- Scientific risks: all-or-none proposition from vaccine R&D. Manufacturers of unsuccessful vaccines failed to convert scientific gains into financial gains.

6. Concluding Notes

- Property rights by innovator companies have been respected so far. What the implementing agencies have focused their energy on is pricing left: drug pricing has taken a more left-leaning policy of government price control. Seems that the implementing agencies, the DOH in particular, are unfortunately stuck in a situation of continuing a policy that so far has not yielded results that will further justify the policy.
- Other policies that the DOH and other government agencies, can undertake that will really address the poor's deep desire to have access to essential medicines and hence. Like bulk purchasing of certain generic essential medicines and distributing them for free to the really poor patients.

6. Concluding Notes

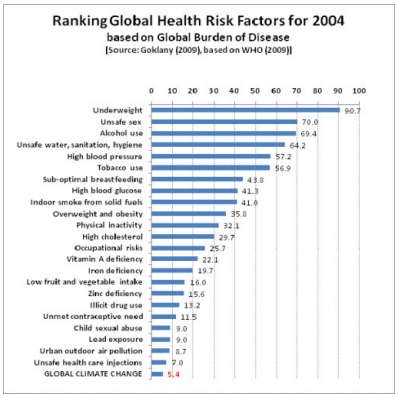
- Improve the business environment in healthcare, attract more players and competitors. More competing drugstores, hospitals and clinics, health insurance firms, pharmaceutical companies both local and multinational. Hundreds of potential players abroad that can come into the country to offer more competition to existing players. Then the Filipino people will have more options.
- Healthcare is first and foremost personal and parental responsibility. Government responsibility in health care should be limited in a few important cases like conditions of health epidemics, taking care of those with physical and mental disability, and taking care of those really poor patients.

• People should not over-drink, over-smoke, over-eat, over-sit in sedentary lifestyle, over-fight, or live in dirty places and don't observe proper hygiene.

→Then demand later that "healthcare is a right" that should be provided by the government to them at low or zero cost.

→ And government will over-tax you and me so it can provide healthcare to those who are less responsible about their personal health.

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



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More inquiries,

www.minimalgovernment.net
minimalgovernment@gmail.com