Essays on IPR and Health, Part 6

Nonoy Oplas
June 19, 2009

Introduction

This is the 6th installment of my "Essays on IPR and Health" series. With the A(H1N1) virus scare still on-going, and the insistence on drug price control as the cheaper medicines law (RA 9502) turned one year old early this month, there are lots of things to write and comment on.

Our bottom line is simple: we advocate minimal or zero government intervention in price setting of private enterprises, whether these enterprises are producing and selling food, beer, softdrinks, clothing, shoes, medicines, cars, computers or bar-b-q. The important thing is to allow as many of those enterprises in each industry and sub-industry as possible, so that there will be vibrant and dynamic competition among them. Competition rewards good enterprises that produce good quality commodities at affordable prices, while it penalizes the lazy and complacent ones with bankruptcy as consumers do not patronize them.

When one or more of those enterprises would resort to unfair practices like producing counterfeit and/or harmful products to the consumers, say resulting in sickness and death, or property confiscation of legitimate private property owners, that is where we believe a strong government should come in – to protect the citizens' right to life, right to private property, and right to liberty.

Eight (8) essays are featured here, lifted from my blog, http://funwithgovernment.blogspot.com, which contains my various writings from IPR and health to free trade, climate alarmism, taxes, etc. One entry here is from my column in www.thelobbyist.biz.

Enjoy reading!

(1) CL, greed and shampoo

May 29, 2009

I got a comment from one reader on the subject of A(H1N1) and compulsory licensing (CL). He said that CL will "taper the greed of these 'innovator' companies.... Medicines should not be treated like any commercial item for sale. CL is the equaliser of the poor countries.... New diseases are golden opportunities for these companies to make more money. I even suspect that some viruses and diseases are created for this purpose."

For us non-producers of a particular material good (medicines, cellphones, shoes, etc.), we can only surmise that the "reasonable" price of something should be only 70% or 30% or just 1% of its actual retail price, and that the greed factor is more than 100%, more than 1,000%, or more than 15,000%. As consumers, we want things to be as cheap as possible, free whenever necessary. So we hate to see something that we deem to be "expensive", even if that expensive thing or service can save our lives or the lives of the people we love, and we conjure or surmise the above figures even if we know very little about the entire research and production process.

With continued use and issuance of CL, it is possible that it will taper the greed factor of innovator pharma companies. It is also possible that the latter will focus their research capability in producing better drugs for skin whiteners, gargles and mouthwash, shampoo, breast or penis enlargers, libido enhancers, etc. Here, if you are an innovator, you will make huge money with zero threat of confiscation of your invention. But if you make an effective medicine against AIDS or swine flu (or dog flu, cat flu, horse flu, etc. in the future), there is always a threat of confiscation of your invention. So you take huge risks.

This conspiracy theory that certain viruses and diseases were created by the innovator companies so that they will make more money, is really fascinating. It's like rightist political parties and politicians were encouraged by the leftist political parties so the latter will have something to lambast and attack. Or those extreme sports and full-body contact sports were invented by orthopedic hospitals and their doctors so that more people will have broken legs, arms and collarbones, and they will make lots of money.

Yes, we need to take a stand against greed. That is why the number of innovator companies should be in the hundreds, not in the dozens. I would like to see hundreds of them slashing each other's throats to develop more blockbuster medicines to beat their rivals, then us consumers and patients will benefit with plenty of choices. I checked the PhRMA website, the organization of innovator pharma companies in America. I counted only 30 such innovator companies. Whereas there are hundreds of hotel chains, of fastfood chains, of dress designers and manufacturers, etc.

India alone has about 22,000 pharma companies. Great. It's just that about 99 percent of them perhaps are generics and copycat manufacturers. The European Council estimates that about three-fourth of all counterfeit medicines circulating around the world are originating from India. This is not the kind of competition that I want to see -- thousands of manufacturers producing cheap but unsafe medicines.

(2) Fake drugs and parallel importation

May 29, 2009

A physician friend thanked me for my paper on counterfeit drugs. She said that "there is a need to strengthen regulation and implement/add requirements to ensure product quality."

For me, more than regulation and government accountability, I want to see more corporate responsibility, that medicine producers and sellers should be directly accountable for all the products that they sell, no one else will be answerable should some things screw up later. Because counterfeit drugs is a very serious and criminal offense. A patient who waits for the medicine to cure him is actually waiting for his illness to mutate and evolve into a more dangerous disease because the medicine that he took was a fake or substandard.

And this is a big issue in parallel importation. If company A imported a cheap but countefeit medicine and the patient here died or developed a new diseases, that company should not say, "Oh I didn't know it was counterfeit, I only bought it from wholesaler X which he got from manufacturer Y in India. You should run after them, not me."

Whoever brought in the medicines, they alone should be accountable. If something bad happens to the patients who bought and took the drugs they sold, the importer and/or seller alone should go to the prison bars and pay indemnity to the affected patients, no one else. BFAD can only do so much, or it can even be possibly corrupted by some pernicious importers. Counterfeit or substandard drugs are sold dirt cheap because there was very little or zero research and innovation involved. By selling cheap, that alone will appeal to many poor patients, especially those who pinned their hopes in the "cheaper medicines law".

If corporate accountability is very clear and transparent, then I think counterfeiting can be drastically minimized. BFAD then will focus its limited resources and manpower on regulating those food and medicinal products produced and sold by enterprises which have hazy brand integrity.

(3) Bitter pill and sour taxes

June 2, 2009

An Editorial of one of the local newspapers here in Manila declared, "End of the bitter bill" (http://businessmirror.com.ph/home/opinion/11120-editorial-end-of-the-bitter-pill.html).

It's about the growing share of generic manufacturers' and distributors' share in the Philippine pharmaceutical industry. Understandably so, With more new players, the market share of the incumbent players, all other things being equal, will decline.

The main issue in the "cheaper medicines law" is how should the various sectors -- government, generics manufacturers, NGOs, media, the public in general -- would treat medicine innovation. Because not one of them is capable of inventing new, more revolutionary and more powerful and safe drugs to evolving and emerging diseases. Only the innovator companies are capable of doing it. That is why provisions on compulsory licensing (CL), special CL, government use, parallel importation and maximum retail price (aka price control), when not justified by clear and apparent health emergencies, are seen as affront or attacks to medicine innovation.

There was one statement of the editorial that is wrong. It wrote, "It's an open secret that many Filipino families spend a huge part of the household budget on medicine".

I checked the National Statistics Office's (NSO) family income and expenditures survey (FIES), latest survey was done in 2006. Percent of household spending that goes to medical care (physician visit, medicines, etc.) was only 2.9 percent. This is not "huge". What was huge was spending on food. Household spending on alcohol and tobacco products was 1.6 percent of total. Well, people would be ashamed to admit in public surveys that they spend 5 percent or more of their monthly spending on beer, whiskey and other high-octane drinks, and cigarettes.

The editorial repeated this wrong claim. In its concluding paragraph, it said,

"we may yet see the day when ordinary families are no longer forced to give up so much of their food budgets just to pay for grossly overpriced medicine. The public has swallowed this bitter pill for decades, and, one hopes, change is real and sustained this time."

Oh well. But back to parallel importation, because the editorial made repeated mention of this scheme. It still baffles me why proponents of cheaper medicines cannot attack high and multiple government taxation of medicines. Combined costs of import tax + import processing fee + import documentary stamp tax + local tax + value added tax can easily hit 20 percent or higher of the retail price of medicines, whether these are imported from India or US or Europe or anywhere else.

So if we succeed in convincing the government to abolish all those taxes and fees, then medicine prices in this country, whether innovator or generic drugs, will easily go down. We don't even need parallel importation scheme that creates a fuzzy system of corporate accountability among foreign drug manufacturers, wholesales, local importers and retailers because these are all different companies. Free trade and the abolition of those expensive taxes, and a welcome mat for all pharma companies from around the world who will clearly and strictly stand by the quality of all the medicines that they bring, that they will accept full accountability and face the prison bars, should they bring in fake and substandard medicines that can cause negative effects to patients in the country.

(4) Fake drugs and SCLD

June 4, 2009

There was a legal opinion column the other day by Atty. Jose C. Sison entitled "Heartless piece of legislation". The author talked about the "Special Law on Counterfeit Drugs" (SLCD, RA 8203 http://www.doh.gov.ph/ra/ra8203, approved on September 1996), in relation to the new "Cheaper medicines law" (RA 9502 http://www.doh.gov.ph/ra/cheaper_drugs, approved June 6, 2009).

The case is about a drugstore in the country which was raided by NBI and BFAD forces upon a search warrant issued by a local court, upon the request of GSK, a UK-based pharmaceutical company, because the said drugstore was selling some imported GSK products without the latter's permission and suspected of being counterfeit drugs. Read the full article here, http://www.philstar.com/Article.aspx?articleId=473691&publicationSubCategoryId=64.

RA 8203 or SLCD defined Counterfeit drug/medicine as:

"medicinal products with the correct ingredients but not in the amounts as provided hereunder, wrong ingredients, without active ingredients, with sufficient quantity of active ingredient, which results in the reduction of the drug's safety, efficacy, quality, strength or purity. It is a drug which is deliberately and fraudulently mislabeled with respect to identity and/or source or with fake packaging, and can apply to both branded and generic products. It shall also refer to:

1) the drug itself or the container or labeling thereof or any part of such drug, container or labeling bearing without authorization the trademark, trade name or other identification mark or imprint or any likeness to that which is owned or registered in the Bureau of Patent, Trademark and Technology Transfer (BPTTT) in the name of another natural or juridical person;

2) a drug product refilled in containers by unauthorized persons if the legitimate labels or marks are used;

3) an unregistered imported drug product, except drugs brought in the country for personal use as confirmed and justified by accompanying medical records;

4) a drug which contains no amount of or a different active ingredient or less than eighty percent (80%) of the active ingredient it purports to possess as distinguished from an adulterated drug including reduction or loss or efficacy due to expiration."

This is a comprehensive definition of counterfeit drug. Though I am not a lawyer, I will take a stab on this issue since it involves intellectual property rights (IPR), a subject which I have some familiarity with.

The author wrote,

"The imported drugs are identical in content with their Philippine-registered counterparts and not in any way adulterated or mislabeled. But Rody was accused of violating Section 4 (a) of R.A. 8203 also known as the Special Law on Counterfeit Drugs (SLCD) which classifies the said medicines as "counterfeit" because they are imported drug products not registered in the name of a natural or juridical person with the Bureau of Patent, Trademark and Technology Transfer of a trademark, trade name or other identification mark of a drug pursuant to Section 72 Part III of the Intellectual Property Code. Can Rody be prosecuted under said Act?

No. With the passage in 2008 of Republic Act 9502, also known as the "Universally Accessible Cheaper and Quality Medicines Act", particularly Section 7 thereof, third parties like Rody have been granted unqualified right to import or possess "unregistered imported drugs". It may be that R.A. 9502 did not expressly repeal any provision of the SLCD. However it is clear that the SLCD's classification of "unregistered imported drugs" as "counterfeit drugs" and of the corresponding criminal penalties therefore are irreconcilably in conflict with R.A. 9502 since the latter indubitably grants private third persons the unqualified right to import or otherwise use such drugs."

I do not know the other circumstances for the issuance of a search warrant by a local court. It is possible that the imported medicine was indeed made by GSK in other countries (India, China, Pakistan, etc.) that contained the correct active ingredients at the correct amount with the correct labeling. If this is so, then Atty. Sison is correct that the parallel importation provision of RA 9502 has decriminalized that practice and hence, Mr. Rody is not guilty.

However, if the imported product was made by GSQ or GSP or any other pharmaceutical company and copied the labels and trademark of GSK, produced a drug with the wrong ingredients, or correct ingredients but at a lower amount as specified, then RA 9502 cannot rescue Mr. Rody because that medicine is indeed a counterfeit. He may not know it because it was only sold to him by some importers who themselves do not know also that the drug was a counterfeit, they simply brought the medicine to the country for the simple reason that it is "cheap".

How did GSK and BFAD know that the medicine is a fake? Maybe some patients who took the medicine bought from that drugstore suffered some allergies or other adverse effects, complained to GSK or DOH or BFAD, the latter bought the same medicine for testing and found that it is indeed a fake.

Atty. Sison then argued why SLCD is a "heartless piece of legislation".

"As written, the law makes a criminal of any person who imports an unregistered drug regardless of the purpose, even if the medicine can spell life or death for someone in the Philippines. It does not accommodate the situation where the drug is out of stock in the Philippines, beyond the reach of a patient who urgently depends on it. It does not allow husbands, wives, children, siblings, parents to import the drug in behalf of their loved ones too physically ill to travel and avail of the meager personal use exemption allotted by law."

Yes, an unregistered and counterfeit drug can indeed spell life or death for a patient in the Philippines or anywhere else. As reported in the most recent report published by International Policy Network (IPN) and co-sponsored by MG Thinkers, "Keeping it real: combating the spread of fake drugs in developing countries", this is how fake drugs kill:

"As fake drugs usually contain insufficient bioavailable active ingredient, a patient who believes he is addressing his disease is in fact going untreated. The disease thus progresses, often leading to death, especially in children and the elderly. We estimate that approximately 700,000 deaths from malaria and tuberculosis are attributable to fake drugs."

Since around 25 percent of all drug supply in developing countries are considered fake, a data coming from the WHO itself, this alarming situation should be fought. The SLCD, therefore, is a practical and humane piece of legislation that should be fully implemented if the country is serious in fighting the spread of fake and substandard drugs.

In the case of patients who took the counterfeit medicine and developed adverse and new disease, who will shoulder for their additional treatment, Mr. Rody and his drugstore? the physician, the importer, GSK, DOH or BFAD?

The issue of counterfeit drugs will be a continuing problem, a problem that was supposed to have been remedied by the SLCD , but contradicted and given new leeway by the parallel importation provision of the new cheaper medicines law.

A continuing and joint vigilance by BFAD and pharmaceutical companies here in the country, domestic or multinational, will help fight the spread of counterfeit drugs. We ordinary patients and citizens are helpless and ignorant in finding out whether the medicine that we take is real or simply made out of insufficient active ingredient, if not simply flour.

And to the basic question: how to bring down medicine prices?

My favorite candidates: One, abolish or drastically cut all those various taxes and fees on medicines. And two, invite all those big innovator companies from the US, Europe, Japan, India, etc., and let them compete here with their more powerful, good quality and safe medicines.

(5) Price control and liberal control

08 June 2009
http://www.thelobbyist.biz/lobbyist.biz/perspectives/columns/back_to_personal_responsibility/731.html

Last Friday, June 5, the Department of Health (DoH) conducted an Advisory Council meeting on price regulation. I was one of those invited, I went there. The issuance of maximum retail price (MRP) or price control of certain medicines was among the topics discussed. Most of the participants in the consultation, including the leaders of the federation of Filipino-owned pharma companies, were not in favor of price control. Why? Because unlike before when the multinational pharma companies were dominating the industry, many local companies are sprouting up and they now see an opportunity of launching effective and highly saleable generic drugs. If they become successful on this later, the dagger of price control will soon hit them too.

A day after that meeting, June 6, the Cheaper Medicines Law (Republic Act No. 9502) turned one year old. Many sectors, including the legislators who crafted and enacted the law, were asking if the prices of medicines have indeed gone down after that.

Last Monday, June 8, there was a Congressional Oversight Committee meeting on Cheaper Medicines Law at the Senate, and the legislators have successfully pressured the DoH that day to issue a list of MRP for selected medicines. Most or all of the news reports that covered that Congressional meeting highlighted the role and statements of Sen. Mar Roxas, Co-Chairman of the Oversight Committee (along with the Chairman of the House Committee on Trade), and principal author of the Senate version of then Cheaper Medicines bill.

The Senator is the President of the Liberal Party (LP) in the Philippines. In theory and historical tradition, a liberal party is the political party of individuals and politicians who value the advocacies for a lean state, limited government, free market, private property rights and individual responsibility. That makes me a fan and believer of the liberal tradition. I have attended last year a seminar in Gummersbach, Germany, sponsored by the Friedrich Naumann Foundation for Liberty (FNFL). Some foundation leaders and speakers who were there were stressing those advocacies, especially the lean state. I would say that some of them were close to the current libertarian philosophy that strongly emphasizes the value of individual liberty in contrast to national and collective liberty. FNFL is a foundation of the German Liberty Party, which is a political ally of the Philippine Liberty Party.

The liberal tradition and re-assertion of individual liberty in the current literature and advocacies of liberal parties allied with FNFL, therefore, contradict advocacies for interventionist and big state, high taxes, forced collective or public property ownership embodied in many nationalist and socialist-leaning political parties and ideologies.

Now, many of the provisions contained in the Cheaper Medicines Law mainly authored by the LP President in the Philippines are actually anti-liberal and very statist. It is understandable if the main authors of that law are from the big state party advocates like Lakas, or left political parties like Bayan Muna. Consider the following provisions:

1. MRP or price control. This is 180 degrees or poles apart from competitive price setting by the market, of huge number of suppliers meeting the needs of a huge number of consumers.

2. Compulsory licensing (CL). Again this is the exact opposite of private property rights. Your invention is also my invention. I have no invention of my own. Pretty soon, very few will dare to become an inventor as there are hundreds of envious eyes watching the inventors and innovators.

3. Government use. A cousin of CL, applicable for medicines whose government-issued intellectual property rights (IPR) through patents are to be revoked and dishonored by the same government for its own use.

4. Parallel importation. This is another cousin of lesser magnitude of CL. Disrespect the IPR and private property rights of an invention; get the goods and drugs from abroad.

5. Silence on high and multiple taxes on drugs. This is approving, allowing and consenting to the multiple taxes and fees on drugs that make medicines about 20% more expensive: import tax + import documentary stamp tax + import processing fee + local government tax + value added tax, etc.

Luckily, the law is not that 100% intrusive. It has some safeguard measures saying that those provisions (1 to 4) cannot be issued anytime, anywhere and arbitrarily. Only on situations of national health emergencies can those confiscatory provisions can be invoked and used.

So now, is there any national health emergency in the Philippines? A(H1N1) flu pandemic? No. But even if the answer is a far-out Yes, then the CL, MRP, parallel importation, government use, should apply only on medicines against the said flu virus. Not on other medicines.

Remember that one of the important ingredients of a competitive market system is the presence of huge numbers of suppliers and producers to meet the huge number of consumers. Supplier A meets consumers one to 3,000. Supplier B meets consumers

3,001 to 5,000. Supplier C meets consumers 5,001 to 9,000. And so on and so forth. So you have different prices for different products by different producers for different consumers and patients with different health needs and budget. Then Supplier A will have charity project for some patients, Supplier B will have charity projects for other patients and communities too, and so on. There is a place and market for everyone.

But currently in the Philippines, there is a very narrow field of competition among pharma manufacturers and distributors in the country for a number of diseases. For some therapeutic category for a particular disease, there are 15 or more medicines from 15 different pharma companies. For other diseases, there are only one or four medicines from the same number of pharma companies. This immediately distorts price setting as it violates the "huge number of suppliers for huge number of consumers" rule of the competitive market system.

One solution to remedy this situation therefore, is to encourage more players from domestic and foreign investors to come here and press on the accelerator pedal of competition. A safe and competitive drug market could be where for every disease, there are at least 10 to 15 different drugs from 10 different drug producers. That means patients and their physicians or health advisers will have at least 10 to probably 50 or 100 different choices of drugs. This should work better for the patients and their health advisers as they have the power to choose, rather than the government politicizing the supply and prices of drugs that reduces the supply and options for essential drugs.

The liberal tradition, in the actuation of the LP President, has been abandoned. Political expediency and opportunism on the way to Presidential ambition in the 2010 elections has caused the liberal control in tandem with price control and choice control.

(6) Drug price control and mutilated intestines

June 9, 2009

I just noticed this news report sent to me by a friend late last year. It's about a survey by an Irish research firm, RMI, comparing the pharma environment in the Asia Pacific. Its report said that out of 14 countries in the region, the Philippines ranked no. 10 in terms of "attractiveness" to more players.

I guess this is consistent with my initial observation that while there are 3 to 4 dozen innovator manufacturers serving the health needs of 9 million Swedish and 4+ million Finns, there are only 2 dozen multinational innovator pharma manufacturers serving 92+ million Filipinos. There are also a few Filipino-owned pharma companies, but all of them I think are generics producers, not a single one can be considered an innovator. Also with the new cheaper medicines law, there are plenty of new generic pharma companies sprouting up, both domestic and foreign.

But I think the survey focuses on the attractiveness of the Philippines and other Asia-Pacific countries in the eyes of the innovator companies, not the generics producers. Because the latter do not worry much about IPR protection. Besides, there are tens of thousands of them in Asia alone, not just dozens or a few hundreds in the case of innovators.

There are dozens of reasons too why people die. For instance, when people eat like a pig, have a body like a pig, then they are likely to develop hypertension- and heart-related diseases. Cheaper medicine is a secondary solution for them, but more of lifestyle change and preventive measures. Or when people drink high volume of alcohol every day, err every night, the chances of contracting various diseases from dilapidated liver to mutilated intestines, lungs and other internal organs are very high. Drug price control can perhaps lengthen their lives by a few months or years. But these people make their own lives cheaper and shorter, perhaps they are rushing to meet their creator more than us ordinary people. Aren't political interventions like drug price control interfering with their desire to live fast, die fast?

Another factor perhaps is that various diseases have evolved and mutated, like before they were just ordinary flu, now there are several types of flu -- cow flu, avian flu, wild cat flu (SARS), swine flu, etc. -- and we can expect new types tomorrow, like horse flu, goat flu, carabao flu, elephant flu, tiger flu, etc. When diseases evolve, medicines that can cure or kill those diseases should also evolve. When the A(H1N1) flu virus showed up, there was no existing medicine or vaccine that can kill the disease, so people use quarantine type of measures to minimize the spread of the disease, but not really kill it.

But with restrictive policies like drug price control, CL and related measures, if I am an innovator company with lots of successful and effective drugs to bring, I would think not twice but thrice, 10 times, before I enter a country that is more than willing to declare a price control to my new medicines. After all, I will be seen and regarded there as a blood-and-profit-hungry multinational pharma company. If I am already a suspected criminal long before I enter, why bother?

here's the news report I was referring to.
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http://businessmirror.com.ph/index.php?option=com_content&view=article&id=3835:rp-pharma-market-still-faces-risks&catid=23:topnews&Itemid=58

RP pharma market still faces risks

Written by Dennis Estopace / Reporter
Wednesday, 24 December 2008 23:28

THE Philippines' pharmaceutical market remains less attractive in the Asia-Pacific region because of difficulties within the country's intellectual property (IP) environment, an Internet-based research firm said.

This is one of three key drawbacks that Dublin, Ireland-based online Research and Markets Inc. (RMI) that will afflict the country's pharmaceutical market in the next five years.

"Despite the considerable forecast annual growth, the Philippines continues to represent one of the less attractive pharmaceutical markets in the Asia-Pacific region," RMI said in a statement released on Monday.

It added that of the 14 markets it surveyed in its business environment ranking, "the Philippines remains firmly rooted in 10th position."

RMI said it forecasts the value of the Philippines' pharmaceutical market to reach $4.09 billion in 2012, up from around $2.6 billion in 2007.

However, the difficult IP environment, modest overall market size and the expected increase in the uptake of generics would hobble the market, according to RMI.

Citing data from a September IMS Health presentation, RMI said that "sales of generic drugs in the Philippines [both branded and unbranded] are almost the same as patented products in some therapeutic categories."...

(7) CHAT discussion list, part 1

June 15, 2009

Last January 19-20, 2009, the Medicines Transparency Alliance (MeTA), an international NGO funded by UK's DFID, WHO, other multilateral agencies, conducted a civil society organizations (CSO) mapping workshop in Manila. Invited were NGO and CSO leaders who have some track record in contributing to health policy discussions in the past, especially in relation to the new cheaper medicines law (RA 9502).

After the 2-days workshop, the CSO leaders who were there agreed to form a coalition among themselves. The goal is similar to MeTA's – pursue medicines and health transparency among CSOs that have interest in public policy discussions. About 25 NGOs were represented there, including Minimal Government Thinkers. Then there were several meetings to draft the proposed charter of the coalition, as well as the draft action plan. MeTA international secretariat will provide some funding for the Philippine CSO coalition.

A few months later, the Coalition for Health Advocacy and Transparency (CHAT) was formally created, this time including other NGOs that were never part of the original 25 or so NGOs last January 19-20.

CHAT has a google groups where members can post many things – seminars, articles, etc. I think the discussion list has about 40+ members, am not sure.

I am among those who frequently post some of my short papers. Then some left-leaning NGO leaders reacted to my papers. The discussions were very long. Their postings though are in Filipino, not in English. I would have wanted to post some of their long discussions here, but this blog has a number of foreign readers who do not understand Filipino language. And I'm not in the mood to translate those kilometric postings in Filipino into English.

Among the articles I posted in the discussion list was about the new report released by the International Policy Network, "Keeping it real: combating fake drugs in poor countries", authored by Julian Morris, Philip Stevens and Julian Harris. The paper is posted in the IPN website (www.policynetwork.net) and in our website, http://www.minimalgovernment.net/media/keepingitreal.pdf.

Among the figures cited in that report were the following:

1. WHO estimates that counterfeit drugs constitute up to 25 per cent of the total medicine supply in less developed countries (LDCs).
2. about 75 percent of imported counterfeit drugs come from India, according to one European Commission estimate; and China is also a significant producer of counterfeit drugs.
3. Fake tuberculosis and malaria drugs alone are estimated to kill 700,000 people a year.

One participant in the list questioned the sources of those data. Below are the data sources as contained in the annex references of the IPN report:

On #1 above: Page 26 of the Report: World Health Organization Factsheet No. 275, refers to a US FDA estimate: "The United States Food and Drug Administration estimates that counterfeits make up more than 10% of the global medicines market and are present in both industrialized and developing countries. It is estimated that up to 25% of the medicines consumed in poor countries are counterfeit or substandard." http://www.who.int/mediacentre/factsheets/2003/fs275/en/ [accessed 6th March 2009]

On #2 above: Pages 9 and 26: One set of figures from the European Commission showed 75 per cent of counterfeit drugs being imported from India, home to around 22,000 small drug producers, many of which are informal (Bate, 2008). -- European Commission Taxation and Custom Union (TAXUD) statistics, 2005.

On #3, the authors explained in page 23, Appendix, their Statistics calculations:

"The World Health Organization has previously calculated that approximately 200,000 malaria deaths per annum could be prevented if the medicines available were of acceptable quality.

This figure was calculated using statistics from the Africa Malaria Report 2003, and a paper on the quality of antimalarial drugs in Africa. The calculations assumed that there were £1 million annual deaths from malaria, with only half of these victims being diagnosed and receiving any treatment at all. Of these half a million receiving treatment, a fifth were estimated to have been resistant to chloroquine and sulfadoxine-pyrimethamine, leaving 400,000 lives capable of being saved through treatment (given existing levels of coverage). The study asserted that, according to the research in The Quality of Antimalarials – A Study in Selected African Countries, up to half of antimalarial drugs in some areas were substandard, and therefore up to half the 400,000 preventable deaths were due to substandard products.

We believe this figure can now be considered conservative. First, resistance to chloroquine and sulfadoxine-pyrimethamine could be removed from the equation, due to the wider dissemination of artemisinin-based drugs. This alone would increase the figure to 250,000 deaths. Second, as explained on page X of this report, drug resistance is significantly exacerbated by fake drugs, with increasing levels of drug resistant malaria along the Thai-Cambodian border attributable to the widespread substandard drugs in that region. Many deaths from drug resistant strands of disease can therefore indirectly be attributed to fake drugs.

According to WHO data, there were 9.3 million new cases of tuberculosis in 2007. Global coverage of DOTS (Directly observed treatment, short course) is said to be 94 per cent, with half of untreated sufferers expected to die. Data on levels of fake tuberculosis drugs is scarce, yet one reliable study (Laserson, 2001) of six countries showed levels of fakes at 10 per cent. By these figures we assume that around 900,000 tuberculosis sufferers are at risk from fake drugs, half of whom (450,000) will die due to the ineffective treatment.

Our total figures for malaria and tuberculosis therefore show 700,000 deaths attributable to fake drugs. It must be noted that due to paucity of reliable data, these are rough, yet conservative, estimates."

Still, that person thinks the above estimation are just hearsay or "haka-haka" in Filipino. Well, if a person or group of persons' mind is too poisoned with biases, no amount of explanation should be able to convince them. A similar situation could go like this:

Person A: I think Gloria Arroyo and family made xx million pesos in kickbacks on the aborted ZTE-NBN project alone.
Person B: why do you think so? how did you arrive at such figure?
A: because of the following considerations...
B: those are just hearsays, haka-haka, bulung-bulongan. Gloria and family did not steal any money from that project.

(8) CHAT discussion list, part 2

June 15, 2009

Another NGO leader advocating drug price control suggested that only like-minded people should become members of the CHAT discussion list. This means only those who favor more state intervention in health and medicine pricing like price control, issuance of CL, etc., should be there, and those who question those provisions should be kicked out of CHAT.

This NGO leader was not there last January 19-20 2009 when MeTA, with the help of some European Council (EC) staff, convened the CSO mapping workshop-seminar. The organizers who spent time and money for that workshop, wanted diversity, not monotony, of perspectives among CSOs and NGOs on medicines transparency. What this NGO leader wants is both price control and thought control.

The discussion list owner and moderator posted and explained that under the CHAT charter, it says:

". . . While bound by a common advocacy, CHAT recognizes the independence of its member organizations and respects the individual positions that may be taken regarding specific issues…. CHAT respects the independence & integrity of each member-organization."

The same NGO leader noted that during the DOH advisory council meeting on price regulation last June 5, DSAP had one voice, PHAP and PCPI had one voice each, while civil society groups have different voices. It is a valid observation. But if we realize that civil society groups should include not only the left-leaning or militant groups, they also include non-political groups like homeowners association, rotary clubs, badminton clubs, cycling clubs, poetry association, etc. Any voluntary organizations, political or non-political, so long as they are not part of any government machinery (local, national or multilateral), can be considered as civil society organization. Such diversity of perspectives is an important characteristics of the concept of civil society.

There was also another posting with innuendos that I do not wish to be harshly criticized in the papers that I post in the discussion list. Far from that, I actually wish more left-leaning guys to debate with, openly and frankly. The triumph of left-leaning public policies in the government is partly due to the absence or weak voice of the free marketers, the believers of free enterprise, capitalism and individual liberty, to square off in various public debates with the advocates of more government, more taxes, more forcible collectivism and socialism, implicit or explicit.

It still escapes my comprehension why despite all of us in the list wishing to have cheaper medicines, many still cannot criticize or attack the Philippine government for imposing plenty of taxes and fees as if medicines are just like hamburger or beer or cigarettes that must be slam-dunked with as many taxes and fees as possible.

I posted my article last May 2008 entitled “Parallel importation vs. free trade" with a single and clear message: If we really wish more competition among pharma companies (innovators and generics alike), if we really wish to bring down medicine prices, we should have 500 or 5,000 or more pharma companies slashing each other's throats in fierce competition here,and not just about 140 pharma companies, both domestic and multinationals (combined PHAP and PCPI members minus drug store-members). And all taxes and fees on medicines should be abolished.

What's wrong with abolishing taxes and fees on medicines, responsible for making drug prices in the Philippines about 20 percent more expensive, that supposedly militant NGOs cannot publicly and strongly advocate? Could it be that many supposedly militant NGOs receive tax money, directly or indirectly from governments and multilateral institutions like WHO, WB, UN and USAID?

If so, such NGOs cannot really be considered as non-government organizations but partial government organizations (PGOs) or government-funded organizations (GFOs), partly or fully. Dr. Robert So of the DOH's NDP-PMU explained it to me one time when I asked him if the DOH also proposed that Congress should also cut or abolish taxes on medicines when they were deliberating the cheaper medicines bill before it became a law. Dr. So said, "Yes, we did raise that issue with them, the Congressmen laughed at us. DOH gets its funding from tax money, Congress is always on the look out where to further raise taxes. And for a government agency that lives off on taxes to demand tax cut is ironic." Dr, So suggested that it is a very valid issue and that NGOs are the "right" entities to push that advocacy. Of course the assumption here is that NGOs do not receive funding from government, whether national or multilateral government bodies, to make them more effective should the tax-hungry legislators and BIR bureaucrats get back at them.

The long and sometimes emotional debates in the discussion list is inevitable. When MeTA organized the CSO mapping workshop last Jan. 19-20, they wanted diversity, not monotony, of perspectives among CSOs that they invited. I was invited by Klara Tisocki of the EC, then helping MeTA. Some EC guys and the DOH already noted our divergence from the "dominant" perspective, our critical analysis of some provisions of then Cheaper medicines bill before it became a law. That's why they invited me.

So if MeTA and CHAT respect diversity, to encourage the sprouting of more ideas from more heads, then the CHAT discussion group alone is already a success. Let people and NGO leaders with varying perspectives on advancing medicines transparency -- transparency not only by the pharmaceutical companies, but also by drug stores, by the government, by the NGOs themselves, etc -- voice out their opinions and perspectives.