Essays on Politicized Drug Pricing, Part 1

Nonoy Oplas

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Introduction

This collection of short essays and articles, is a take-off from my earlier series, "Essays on IPR and Health". Parts 1 to 6 of that series are posted in our website, www.minimalgovernment.net.

These papers were posted in my blog, http://funwithgovernment.blogspot.com. Two were posted in the online magazine, www.thelobbyist.biz. And since we are in a drug price control period in the country, I should write more short papers on this topic in the coming weeks and months. Hence, Parts 2 and more will be forthcoming.

(1) DOH meeting on price regulation, Part 1

June 21, 2009

The Department of Health (DOH), as mandated by the Cheaper medicines law (RA 9502) is to form an Advisory Council on price regulation. The Council was formed early this year and so far they have conducted 5 meetings. I have attended the last 2 meetings -- last June 5 and June 19. I have not attended the first 3 council meetings, two of which were scheduled on days that I was out of the country.

The Advisory Council has a good mixture of participants. I categorize them into 5 groups here:

(1) the two federation of pharma companies, PHAP and PCPI (Pharmaceutical and Healthcare Association of the Philippines, and Philippine Chamber of Pharmaceutical Industry, respectively). The former is composed mostly of multinational pharma manufacturing and trading companies, while the latter is composed of Filipino companies.

(2) drug retailers, particularly Mercury Drugstore, the Drug Store Association of the Philippines (DSAP), and the Generics Pharmacy.

(3) the civil society groups, including Minimal Government Thinkers, Medical Action Group (MAG), Cancer Warriors Foundation (CWF), Ayos na Gamot sa Abot kayang Presyo (AGAP), others.

(4) the multilateral institutions like the European Council (EC), World Health Organization (WHO), GTZ (German foreign aid), etc. Although I think not all of them attend the meetings everytime, only on issues where they have some involvement or projects. The UPSE Health Policy Development Project (HPDP?), funded by USAID I think, also attends the meeting. And finally,

(5) other government agencies like the Department of Trade and Industry (DTI), Bureau of Food and Drugs (BFAD) and the Philippine International Trading Corporation (PITC).

The 4th meeting last June 5 was held at the WHO Western Pacific Regional Office (WPRO). The main agenda then were (a) WHO's national essential medicines facility (NEMF), (b) list of medicines for possible issuance of maximum retail price (MRP), and (3) a draft proposal by DOH to regulate discount cards by pharma companies.

The goal of NEMF is to "harmonize and ensure uniform standards of procurement across the public sector, ensure selection of reliable suppliers of quality products,..." The essential medicines targeted are for (a) TB, HIV and malaria, (b) vaccines, (c) emergency obstetric care, (d) chronic diseases, (e) neglected diseases, and (f) PhP program and "botika ng barangay" (village pharmacy).

The discussion on list of medicines for issuance of maximum retail price (MRP) or price control was long. DOH UnderSecretary Alex Padilla, USec for health regulations, narrated how difficult it is to face sometimes legislators who want price control, just to show to the public that the government is indeed "serious" in enforcing the cheaper medicines law. DOH understands that it's not easy to issue price control and fully implement it, but they are sometimes castigated in media by the legislators as "in cahoots with multinational pharma".

One will understand if PHAP will oppose drug price control because it is the patented and branded drugs by multinational pharma companies that are most likely to be targetted. One may even assume that PCPI will not object to price control because the products of their members are non-patented and generics. But PCPI leaders were very vocal in opposing drug price control. This is because price control is essentially penalizing success. Any drug that has become popular and highly saleable, whether patented or not, can be a target for price control. Many PCPI members are now good manufacturers, they are capable of producing popular medicines. That ugly state intervention in pricing called MRP will soon hit them.

I spoke, of course, on this subject at the meeting. I noted that price control is a favorite advocacy of socialists under economic central planning regime. It is driven by plain envy with "suffering of the masses" as smoke screen.

Suffice it to say that with the exception of 1 or 2 voices in the meeting, almost everyone, including drug retailers, agreed that imposing price control at this time is ill-advised.

The subject of DOH regulation of discount cards by some multinational pharma companies was tackled next. It was the first time I heard that it is an issue. The DOH wanted to produce a draft Administrative Order proposing that whatever is the current discount price by those pharma companies (usually 50 percent off their regular price) should become the “universal price” and must apply to all customers and patients, with or without any discount card.

There were two major arguments I could remember, that were raised in favor of this move First, discount cards favor the rich, they are the ones who can afford to see a doctor regularly and doctors give out discount cards. And since discounts represent some revenue losses to the manufacturers, such loss has to be recouped from the regular customers, the non-card holders, who are the poor. Second, discount cards allow the pharma companies to have access to some health record of the patients, and there is ethical violation there.

I spoke twice on this subject. First, discount cards I think are marketing tools by suppliers and manufacturers; it is a unilateral, voluntary act on their part, hoping to increase their revenues and profit either in the short- or long-term. Such voluntary acts therefore, should be encouraged, not penalized. When discount cards are to be banned and whatever discount price was to be made mandatory, a cousin of price control in effect, I think this is penalizing those who initiated the discount. Such mandatory pricing would be more palatable if government will also offer mandatory reduction in business regulations and taxes for the affected suppliers. Since this is not forthcoming, then the move is pure penalty, not reward for a good job done.

Second, giving out information about the patient's health record is no different from filling up an application form to apply for a credit card or open a bank account, where the applicant is giving away his/her personal information like monthly salary, if the house is owned or rented, how many cars owned, etc.

The reply to my points were as follows. On the first, it is not easy to expect the government to cut business regulations, much less cut taxes, for suppliers who are offering unilateral discount promotions. On the second, information via credit card application is way below personal health information, they are not comparable. Health is on the top, above almost everything else. Hence, personal health information should not be accessed by just anyone, much less pharmaceutical manufacturers.

Anyway, we were asked to submit our formal position papers on this subject as the Office of the President is also waiting for the proposals of the DOH as collated from its various consultations.

It was a productive and very informative meeting, and I thanked the DOH officials and staff who were there for conducting such meeting and inviting a diverse group of participants.

(2) DOH meeting on price regulation, Part 2

June 21, 2009

The 5th Advisory Council meeting on price regulation was held last Friday, June 19, at the DOH. There were 3 topics discussed. First, an update on drugs that were recommended for MRP issuance by the President. Second, the proposed administrative order by the DOH on how to implement the MRP once the draft Executive Order (EO) is signed by the President. And third, the electronic data base on comparable drug prices, under the DOH website.

The DOH Secretary submitted the draft EO to the President only last Tuesday, June 16. The first official announcement of list of drugs under MRP was last June 8, during the Congressional Oversight Committee hearing at the Senate, where Sen. Mar Roxas, an LP Presidential candidate, most likely pressured the DOH to produce a list of drugs for MRP. The timing was suspect because it was one year since the enactment of RA 9502, June 6, 2008, and there was no clear national health emergencies.

Were there new list of drugs for MRP? Maybe, no one knows yet except the DOH and the Office of the President. Between the announcement at the

Congressional Oversight Committee meeting last June 8 to June 16, there could have been new drugs or those in the mentioned list may have been removed. The DOH said from 100 molecules, they later pared the list down to 25 molecules. The final list is with the President, and she will also make her own consultations before signing the draft EO.

Many of us who attended the meeting last Friday were also surprised that the MRP was pushed through considering that the majority sentiment during the 4th Council meeting last June 5, was that MRP is not necessary now, it should have not been pushed. PCPI reiterated their position that they are not in favor of issuing MRP now. I also spoke and argued that price-setting is not a function of the government. Since we advocate minimal government, there is no way that we can support State intervention in setting prices, much less in price control.

After another long and extended discussion on the inappropriateness of medicine MRP, the topic shifted to BFAD's Administrative Order (AO) on how the draft EO will be implemented. About 3 pages long, saying that drug manufacturers, distributors, retailers, etc. should put the label "price not to exceed the MRP of ____".

This proposal was shot down, not only by the pharma companies (multinationals and domestic) but also by leaders of drug stores. The main argument is that if there are signs that the prices of drugs that have been identified for MRP are coming down to 50 percent or lower, then no labeling will be necessary. Voluntary compliance should be encouraged. Since there are around 5,000 to 7,000 drugstores nationwide, the labelling will have to be done there – drugstore by drugstore, pack by pack, capsule by capsule, etc. This will present a new logistical nightmare. There was a proposal to have a "transition period" of 3 months between the issuance of the EO and the actual implementation of price labelling. Some civil society groups objected, but they were later convinced of the complexity of hurrying the labeling.

I also suggested that since the government has intervened a lot already in drug pricing, government should show some sacrifice. For instance, should price labeling be necessary for some drugs, it should be the government that should do it, not the drug suppliers who already suffered huge revenue cuts, if not suffer losses, with the mandatory and forcible price control. Many participants from the government agencies howled in disapproval to my proposal.

The 3rd and last agenda was the electronic data base for comparable drug prices. Although there are some noble goals for coming up with this list, aside from being mandated or suggested by the new law and its implementing rules and regulations (IRR), the list is projected to raise more high expectations from the public which will only result in high disappointment. For instance, some

drugstores will cite prices for the e-database that are lower than their actual retail price and produce various reasons why they did so.

One vocal participant in the meeting commented on the side that we need minimal government on issues like drug pricing. Thumbs up to him, actually a former friend way back from our undergraduate days at the University of the Philippines (UP) in Diliman campus.

Earlier, there was a discussion how to expand the number of participants in the Advisory Council meetings since certain important players were left out. For instance, people have assumed that all multinational pharma companies are members of PHAP and so, PHAP officials can articulate their sentiments. Turns out that there are 3 multinational pharma companies that are not members of PHAP – Pfizer, Servier, and Merck. So these companies are expected to be invited in the next Council meeting next month, before the State Of the Nation Address (SONA) of the President.

The quality of discussions and debates in the Council meetings is high and very transparent. People who have "great" ideas on something can expect that it can be shot down if such grand ideas are not backed up by robust philosophies and solid data. Unlike in Congressional hearings where the presence of legislators is very imposing and dominating, the discussions in the Advisory Council meetings are more free wheeling, fast and frank.

Meanwhile, what can those multinational pharma companies do to question the inclusion of their popular and saleable products in the MRP list? I think they should write to the President, arrange an industry delegation (PHAP, PCPI, other pharma companies that belong to neither) for a meeting with her. There is a unanimous voice from the industry that MRP will be counter-productive at this time, especially with no clear and apparent national health emergency.

Of course there is a possibility, even a small one, that when the pharma industry leaders would come to malacanang for a dialogue with the President, political and financial extortion is a possibility. The 2010 election is less than 11 months from now, all politicians and political parties are stockpiling money and cash.

But then again, this is just a conspiracy theory.

(3) Drug price cut without government price control

June 29, 2009

I read the news report below in the Inquirer today. Sanofi Aventis is cutting the price of its anti-diabetes medicine for patients affiliated with ISDF, a health NGO. I think this is a welcome move, a unilateral action on the part of a pharma company to bring down the price of its anti-diabetes medicines for selected, target patients.

My brother who died of prostate cancer a few years ago, was also diabetic. It was a deadly combination, diabetes + prostate C. He was lucky to have a private HMO + my well-off sister's support who practically picked up most of the tab in his 2-years of messy and expensive treatment including chemo. The government? It was collecting taxes left and right for all the medicines that my dying brother was taking.

In the past 2 meetings of the DOH Advisory Council on price regulation that I have attended, there was a general feeling that whatever price reduction that a pharma company can give to certain patients, should be made as mandatory and "universal price" for all other patients.

I am not exactly in favor of such proposal because the pharma companies, domestic or multinational, that extend such kind of price cut to certain groups or patients, have educational programs for their patients. They know who are the people buying their medicines, especially the poor patients, so the pharma companies that initiated the price cut can also give additional medical advice, like how to avoid diabetes in the first place. If such initiative is ok, Sanofi will make it a nationwide program, meaning nationwide price cut of their anti-diabetes medicine. Maybe through the patients' pysicians, if no NGO support groups like ISDF are not around.

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http://newsinfo.inquirer.net/inquirerheadlines/metro/view/20090629-212891/Price-of-antidiabetes-medicine-cut

Price of antidiabetes medicine cut

By DJ Yap
Philippine Daily Inquirer, 06/29/2009

MANILA, Philippines—Combating diabetes among indigent Filipinos has taken a step for the better—and the cheaper—thanks to a new partnership between the pharmaceutical company Sanofi-Aventis and the Institute for Studies on Diabetes Foundation Inc. (ISDF).

The two institutions launched on June 23 a new program called "Innovation for Life," a new, equitable, tiered-pricing approach toward increased access to insulin glargine (Lantus)—Sanofi-Aventis' diabetes medicine—among patients who could otherwise not afford it.

Dr. Ricardo Fernando, the founder of ISDF, said the project, which is seen to benefit more than 500 ISDF patients at the outset, was developed "not only for the next few months but for the long term."

Patients who are accepted to the program stand to get substantial discounts on their Lantus medication, which, depending on their condition, typically costs from P100 to P1,000 every day, organizers of the project said.

"We have to remember that the most expensive medicine is the one that does not work," Fernando said at the launch of the project at the ISDF offices in Marikina City….

(4) An explosion of drug stores

June 29, 2009

Last week June 25, I dropped by Region 1 Medical Center in Dagupan City, Pangasinan, after my meeting at the DENR office not far from that hospital.

What amazed me was the huge number of pharmacies and drug stores in front of the hospital. I counted 16 total! Front-right of the hospital, 7: FGG generics, Maia's, Buy Low, Neslen, Aurora, D'Calidad, and Cyprus. Front-left of the hospital, 6: Roslin, REM Citimed, Urduja, St. Vincent, Pong's, The Generics. Beside the hospital, to its left, 2: Mercury and another Roslin drug store. And within the compound is the hospital pharmacy.

Surely the patients of that hospital have a wide range of options of where to buy their medicines cheaply. I think that with this stiff and fierce competition among different drugstores and pharmacies, medicine prices should be generally low.

The next question is whether all the medicines sold in those different drugstores are safe and real, not the counterfeit, sub-standard and unsafe ones. How would patients know? Not a bit, almost. Unlike a fake bag or shoes or DVD, fake drugs are difficult to discover if one is an average consumer.

Nonetheless, one goal of the cheaper medicines law, of having cheaper medicines, is partially achieved by having a stiff competition among different drug stores and pharmacies.

(5) Drug discount cards on facebook

July 19, 2009

Yesterday, after reading some Manila newpaper columnists' articles on drug discount cards, I posted a status in my facebook account. Shortly after, several friends commented. Below are the actual comments. I thank them -- Elizabeth Cueva, a friend from UP and now a practicing lawyer in NYC; Eric Tolentino also from UP, and Gene Peters, for giving me permission to post here her comments.

Below are the exchanges:

Nonoy Oplas (is) Reading a number of news articles and opinions on drug discount cards. I only realized recently this is a big issue here in Manila. A marketing promo is now being pushed to be a mandatory promo; if you don't do it, you're an evil. hmmmm...

hi nonoy. isn't this really a way to track the doctor who prescribes the company's medicines instead of really giving discounts. great way to go around the senior citizen's benefit too! - Gil

Hi Gil. Yes -- track the doctors, the med reps, the patients, the drug stores, everyone who willingly agrees to the scheme, in exchange for lower price and continued patronage of a particular drug. If those pharma companies will distribute their discount cards to all doctors nationwide, let them continue their marketing promo, the State should get out of such promo. The State can invite more pharma companies to come in, launch their own promos, overall the patients will benefit. -- Nonoy

Yeah, the State should get out of the drug discount promo deal. It defeats the purpose as a marketing tool. The market should drive it. People in the Philippines are actually luckier when it comes to access to vital life-saving medications. The state of the current U.S. health care system sucks big time. -- Elizabeth

Ah, many Filipinos do not realize that, thanks Elizabeth. Instead of recognizing the presence and merit of the few multinational pharma companies in the Philippines -- there are soooo many other multinational pharma companies that are not yet here that could help increase competition -- those few are being demonized. Even their promos, a unilateral and voluntary act on their part, is being seen as an evil scheme. -- Nonoy

I should know. My grandma and my mom are both pharmacists/ med techs there and their family used to own boticas in the Sampaloc, Manila area. The prices were lower with these "mom and pop" boticas which were wiped out by big drug conglomerates Mercury, Commodore. Still, the prices are more affordable than in the U.S. and generic medication more accessible. Thanks to Flavier for pushing the generic brands.

Here in the U.S. when I lost a job, I lost employer-subsidized medical and drug insurance coverage. I now have to shell out money for COBRA medical/drug insurance coverage and IT HURTS. The coverage is not even enough and I have to shell out more every visit to the doctor for treatment or prescription. So, for me prevention is really key. It is really fatal to get even slightly sick here in the U.S. without medical or drug insurance coverage because of the prohibitive price of medical care, treatment and medicines. -- Elizabeth

Commodore drug, wala na yata dito. Mercury and Watsons are the biggest drugstores now. The mom-and-pop type of boticas are partly being wiped out by government regulations. They make only about 5 to 15% profit margin because of competition, but the senior citizens discount is 20% mandatory. Such loss is not even tax deductible. -- Nonoy

I read somewhere that in countries like India, exactly similar drugs (hypertension) can be purchased for just 1/5 the cost here. How true? And how can I get my hands on those drugs? Gimme, gimme... -- Eric Tolentino

Hi Eric, PITC, a government corporation, made that study, no one bothered to double-check the figures and computations. Even if the numbers are correct (ie, only 1/5 of price in India), those are prices there, not here. When those cheap medicines are imported into the Philippines, there are several costs to include: transport and storage, taxes (import tax, import processing fee, import doc stamp tax, local tax, VAT, etc.). When sold in drugstores, they are expensive again.

Also, note that it's under a parallel importation scheme. The foreign manufacturer abroad (say GSK or Pfizer or Roche, etc.) is different from the foreign wholesaler or aggregator, is different from the Phil. importer and distributor. If the imported drugs turn out to be fake or substandard causing allergies or death to patients, difficult to pinpoint who's to blame. -- Nonoy

Health care problems since then is a big issue in Manila, with a growing populace and detiriorating quality of living manilans are more succeptible in many forms of ailment.. the real problem here is our policy on health care are lame and useless thats why they put another issue on top of one that will never solve the basic problem of health care for all, benefits for some sectors are mere

band aid solutions..while pharma companies rakes in the profuts.. of course with the help of our caring doctors. -- Gene Peters

Hi Gene, in the first place, health care is personal and parental responsibility, not govt. responsibility. People should not over-drink, over-smoke, over-eat fatty food, over-sit and live sedentary lifestyle, over-fight and get into frequent rumbles, etc. Pharma companies exist because there is a demand for them, the same way that beer, burger and cellphone producers exist because there is a demand for them. When medicine prices are high, blame the govt. high and multiple taxes on drugs, blame the lack of competition among pharma companies because of govt. bureaucracies. Soooo many multinational pharmas, the innovator ones especially, are not yet here in the Phils. -- Nonoy

Health care is also a government responsibility, but the policies must be salutary and not detrimental to general welfare. Just like what Gene said, it should not be a band aid approach. So, for me, government's role is not really to regulate and restrict but to facilitate access to high quality health care with lower costs for all. -- Elizabeth

Ok, I forgot to add in my earlier reply to Gene that government has secondary responsibility to health care. Like in cases of pandemic and outbreak of contagious diseases. In the absence of such health emergencies, government should back out, allow more competition among private hospitals and clinics, more pharma and drugstore companies, etc. When one or some pharma companies introduce fake and substandard medicines that can result to more disease, if not death to patients, government comes in to enforce the rule of law -- no killing, no harming, no stealing, etc. -- Nonoy

(6) **Discount cards vs. discounted competition**

09 July 2009

http://www.thelobbyist.biz/lobbyist.biz/perspectives/columns/back_to_personal_responsibility/751.html

In a competitive business environment, enterprises resort to various forms of competition in terms of (a) quality (who has the most durable, most reliable, most effective, safest, and so on) and (b) price (who has the cheapest, most cost-effective).

More players, more competition, more marketing schemes and more price discounts promo. Ultimately, the consumers will benefit because they will have lots of options and choices among the various producers and suppliers of the

products that they need based on their particular tastes, preferences, needs and budget.

The proper role of the government therefore, is to encourage more competition among different enterprises and producers, not stifle it. And for government to successfully encourage competition, all it has to do is practically do nothing. Do not over-regulate. Do not bureaucratize. Do not impose high and multiple taxes and fees. Do not intervene anytime for any alibi. Just step back and watch for whoever is doing foul and harmful schemes. Like producing cheap but poisonous food and drinks, cheap but structurally defective houses, cheap but fake and substandard drugs, those resorting to arson and sabotage against competing firms, and so on. People will really appreciate it when government comes in and intervene in cases like these because there is physical harm being done or about to happen to the public.

Recently, discount cards and coupon promos by some drug manufacturers became a negative public issue. The issue is that if those pharmaceutical companies are capable of selling their drugs (patented or generic) at 30 to 50 percent discount or higher to those who hold their discount cards, why not make it a "universal" price for all consumers, with or without a discount card. Why give those discount cards only to doctors in expensive clinics and hospitals for their rich and the middle class patients, why not give the same privilege also for patients who cannot afford to see a doctor.

Since there is obvious "class" discrimination among rich and poor patients, government should come in and mandate or force those drug companies to remove those discount cards altogether and sell their drugs at the existing discount price.

This does not seem to fall in the above definition of where government is expected to keep out or come in. There was no harm to the public when some companies would give price discounts to patients who voluntarily signed into some discount cards. The patients signed in voluntarily like they sign in to their yahoo or gmail or facebook account. The service provider – web-based email or social networking or pharma company – asked the person to give his/her name, age, etc. in exchange for a particular favor, like free email account or highly-discounted medicine prices.

As discussed above, price discounts and various forms of marketing promo are expected from enterprises which are operating in a competitive environment. No discounts, less customers, less revenues, less profit, if not losses. Very simple.

Should the State, through the Department of Health (DOH) and/or the Department of Trade and Industry (DTI) and other government agencies devote

their thin resources into coercing companies to another set of price control, then monitor for their compliance or non-compliance, then wait for the "offending" parties' position paper in a public hearing, then prepare charge sheets and go to the courts if necessary. Is this the right way to spend taxpayers' money?

It is true that those discount cards may be used by the issuing pharma companies for their "intelligence gathering". If those pharma companies will distribute their discount cards to all doctors nationwide, let them continue their marketing promo. Other competing pharma companies can bring down the prices of their drugs without discount cards, threatening the marketing promo of the earlier companies that issued discount cards.

Whatever dynamics and counter-promos in quality and price competition among the various enterprises, the State should get out of such deals. By keeping out, the State is indirectly inviting more pharma companies to come in, both domestic and multinationals, to launch their own promos, and ultimately the patients and their families will benefit.

The State should reserve its coercive resources in tracking and controlling those pharma companies that produce and/or import fake or substandards drugs because of the harm they bring to the public. For these companies, they can always price their drugs at just 1/2 or even 1/5 of the supposedly comparable drugs by other companies because the former just used flour or any cheap and medically useless substances in producing their own "drugs". Isn't this a better use of the taxpayers' money?

There are still soooo many multinational innovator pharma companies abroad that are not yet in the country that can help increase competition. These multinationals are global corporate brands that are too scared to be involved in even a single case of producing fake or substandard or ineffective drug. Why should the Philippines be satisfied with the current 30 to 40 multinational pharma companies and about the same number of reliable domestic pharma companies, when there is a potential of 200 to 500 reliable companies who can offer more choices for the Filipino patients?

The State, through the Department of Finance (DOH) and the Bureau of Internal Revenue (BIR) should also consider cutting drastically the various taxes and fees that they imposed on medicines and active ingredients.

There is nothig to fear in discount cards. We should be afraid in discounted competition instead. Monopolists, oligopolists and political rent-seekers thrive in an environment of discounted and limited competition.

(7) Drug pricing and IPR on facebook

July 23, 2009

The other day, I posted some of my thoughts on drug price control in the Philippines in my facebook status.

I got several comments after that. The one with the most comments was Francis Bonganay, he's the editor of the forthcoming paper, "The New Commonwealth Herald." Francis gave me permission to post his comments in this compilation in my blog. The others – Boying, John, Patrick – did not reply yet to my request-for-permission-to-quote posting, so I won't give their full name and affiliation. What is important here is the articulation of their comments which other people may possibly share with.

Here's the compilation of such thread:

With drug price control, if I am a pharma company with a revolutionary and very effective drug against say, cancer, but the drug is expensive, I won't bring that drug to countries that have official drug price control policy. I will be seen there not as a revolutionary innovator but as a blood-thirsty, profit-hungry multinational-capitalist firm. -- Nonoy

Are you saying that price control is crude way to control the price of drugs? or that govt should not ever control the price of drugs (even if the price in its jurisdiction is significantly higher than in other jurisdictions)? -- Boying

Government should not ever control the price of drugs because pricing actually serves a purpose in the economy. It allows the supply of drugs to remain available for when it is needed. This is why medicines in a hospital are usually 3x the price of drugs found at the store. If it wasn't, people would buy from there first and the hospital would have shortages for their patients. Now, to keep pricing down, the government should also not ever enfore copyright laws. -- Francis Bonganay

Price control distorts market signals that direct producers use to direct their business. While favoring consumers (especially the poor), price controls in the

end will result in negative outcomes as its stifles competition by removing the incentive to innovate and discouraging new entrants. – John

Thanks John, Francis. Price control is often driven by envy, not rational thinking. For instance, currently there are 200+ different drugs against hypertension, prices range from P3/tablet and up, but people are so fixated with Norvasc (P44/tablet), they don't consider the 200 or so competitor drugs that are priced lower. So price control is on Norvasc. -- Nonoy

If all markets were like that you wouldn't have any money to develop it in the first place! -- Patrick

Not true. If you actually did an audit on pharmaceutical R&D, you'd find that almost 80% goes to administrative overhead, government lobbying (and red tape), and an extremely costly trials system... once more organized by the government. – Francis

Currently all medicines vs. AIDS can only keep the virus at bay, not really kill it. If I am capable of inventing a medicine that can really kill the virus but other companies will say, "your cost of R&D is yours alone but your successful invention is also my invention", then why would I iinvent that drug?

If your figure of 80% of R&D is admin and unproductive costs is correct, then why don't those tens of thousands of generics manufacturers become innovators too, and make money early instead of just waiting for the drug patent to expire? -- Nonoy

Because the government doesn't like it when there are drugs out there without their holy stamp of approval (like recreational pharmaceuticals). hence the tests and lobbying required. don't forget the whole patents thing if you ever have a similar molecule in your lab.
http://mises.org/article.aspx?Id=641&month=30 – Francis

It's the desire of the innovator company that its invention will be protected from poaching and being claimed as "that igreat invention is mine too" by any company. As long as this protection can be assured, by govt. or NGOs or private contracts, no problem, provided the innovator should be encouraged, and protected, not discouraged. Otherwise, societies will be full of copycatters only, very little or few innovators. -- Nonoy

Yeah, its the "common sense" idea that everyone has. Omigod! No protection? Who will want to do stuff if everyone is gonna copy myself. That's why its real hard to sell the idea that "No, with all that protection and patents gone there will be MORE INNOVATION." -- Francis

Most inventors and authors are more than willing that their intellectual output will be shared immediately to everyone for free. I write an original article based on a book that I have read or a conference that I have attended, I post my article in my blog, everyone else can read and see it for free. Fine. There is very little cost for me to bother asking people to "pay" for my article. The cost of enforcement is million times higher than whatever projected benefit.

But for those whose costs are very high and they are not willing to share their invention for free, then they should be respected. -- Nonoy

I think the big contention is not property rights, but enforcement of intellectual property. -- Francis

Private property ownership is important under capitalism. Absence of private property, through forced collective property ownership, means society is under socialism. If people want enforcement of their IPR -- say a fee for every downloaded article from the author's website, then there is a market for that. People who think the author really makes sense and the fee is affordable, they will pay. For those who think otherwise, they can "boycott" that author.

The same logic for drug invention and patent applies. If people think the drug by the innovator company is too expensive and there are alternative drugs, they will boycott that drug. If they think that drug is too life-saving while other alternative drugs are not so effective, then they will pay.-- Nonoy

(8) MRP, GMA, DOH-K, NGO

July 26, 2009

It is said that in a welfare state, politicians are well, taxpayers pay the fare. In the case of the health sector, often an emotional subject, politicians are not far behind.

In the current debate on drug price control or maximum retail price (MRP) as stated in the new law, acronyms of big politicians are indicated if not implied.

MRP becomes "Mar Roxas for President", in reference to Sen. Mar Roxas who authored the cheaper medicines law in the Senate and is running for President in the elections next year. It was his strong pressure during the Congressinal Oversight Committee on the cheaper medicines law that forced the Department

of Health (DOH) to produce a list of medicines to be issued the MRP or price control.

GMA now becomes "Government-Mediated Access" price of the medicines that have voluntary price reduction by their multinationals manufacturers. GMA of course, refers to the President, Gloria Macapagal-Arroyo. The list of drugs under GMA was released today (or perhaps yesterday) in big newspapers. Tomorrow will be a very big day for the President when she delivers her 9th and last State of the Nation Address (SONA) in her 9 years in power.

The DOH Secretary, Sec. Francisco T. Duque III, has his own motto for the Department even before the current drug price control debate. The motto is

OK-DOH-K!

Which sounds like "OK Duque".

Now I am tempted to join the fray and insist that the real definition of NGO is not non-government organization but rather, Nonoy Gwapo Oplas. hehehe. And of course, many will protest with this new nomenclature while a few will laugh.

Those who will protest are most likely of the grim-and-determined type of militant NGOs while those who will laugh have good sense of humor.

Happy weekend.

(9) Health politics

July 28, 2009

I am thankful to the DOH that I've been a part of the DOH Advisory Council on price regulation -- a multi-sectoral, multi-interest body that deliberates on whether government shoup dip its hands in setting or dictating the price of certain medicines, on whether to allow or restrict drug discount cards, and related topics. The DOH's hands are tied here because the Cheaper medicines law mandates it to take up such matters.

I perfectly remember that the subject of voluntary drug price reduction was extensively discussed during the 4th and 5th Council meetings last month, and I realized there that for the first time perhaps in the history of the Philippine pharma industry, the multinationals and Filipino pharma companies were united -- in opposing mandatory government price control.

Last Saturday, July 25, the Advisory Council released its first Resolution, "Implementing the voluntary price reduction for at least 16 molecules (or 41 drug preparations)". It was signed by various stakeholders and participants that regularly attend the Council meetings. I wasn't there because the schedule of the meeting and announcement was moved from 1pm to 10am, and I have an obligation for my daughter in the morning of that day.

The big problem in the implementation of 50 percent price cut (or any other rate) are the small drugstores in the provinces which have no computerized system in tracking their inventories, sales, orders, and so on. Otherwise, the big drugstores (Mercury especially, Watsons, PITC Pharma, etc.) can easily comply within the 1 month transition period (August 15 to September 15) before penalties for violation will be implemented.

The list of medicines under voluntary price reduction was advertised in big newspapers last Sunday (and perhaps in other days).

But politics set in, as usual. What could be plain "voluntary price" became "Government Mediated Access" (GMA) price, referring to the initials of the name of the President of the country. Which shows once again the ugliness of government intervention. When government comes in, there are always "bahid politika" or political motives, and there are always politicians taking the undeserved media credits.

In reality, government produces not a single tablet, not a single medicine. Government only produces regulations, prohibitions and ots of paper work that all private enterprises (from barber shop to food shop to pharma companies) must comply.

When my brother was still undergoing chemo treatment (prostate C), one injection was worth P25,000, nearly P3,000 of which was VAT alone. Eight (8) or more treatments, not effective enough because the cancer virus has spread to his body already. A last-attempt chemo just to prolong his life was worth P90k (of which around P10K was VAT alone). Days before his death, his pain was beyond description. On his last few hours though, he was already unconscious and perhaps, rested.

Cancer and Taxes, they have one similarity: they both suck, they both kill.

I know of some rich people who have cancer. They can afford even the most expensive medicines, even the most expensive doctors. But current breed of

many medicines are not powerful enough to beat and kill cancer (or AIDS and Alzheimers). So they die quick once the virus spreads in their body.

Some NGO leaders in our local health coalition in Manila portray me as a "traitor" for consistently opposing government price control, government confiscation of private property in IPR. But I sincerely believe in medicine innovation. Only new, revolutionary, more powerful, real killer drugs of killer diseases can save lives. The generics and cheaper versions can follow later.

(10) Double price control

August 10, 2009

Senior citizens (60 yrs old and above) and persons with disabilities (PWD, like blind, mute) are entitled to 20 percent discount on medicines. That's price control #1. Then there is the government-mediated and government-mandated 50 percent price cut on medicines. That's price control # 2 that will start 5 days from now, August 15.

There have been a number of confusions already on price control #1 alone. Among these are the following:

One, if the senior citizens are buying drugs that are obviously for their grandchildren or for other people, can the drugstore refuse to give the mandatory 20 percent discount? But there are clear penalties if the seniors will report to the Department of Health (DOH) and the police.

Two, if a person comes to a drugstore and makes signs that he/she is mute and deaf and demand the 20 percent mandatory discount, how will the drugstore staff know that he/she is indeed mute-deaf and not just pretending?

Three, most small drugstores just make 5 to 10 percent profit margin because of stiff competition among them, but they are all forced by the government to give 20 percent discount to PWD and senior citizens, how will they recoup the losses?

When price control #2 is added to the above, here's the 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!

So pharmaceutical companies and drugstores, big and small, are wondering how to deal with this kind of double price control and still survive. And there are uncontrolled taxes and fees on medicines alone, uncontrolled taxes and fees on

entrepreneurship and doing business, the government is not budging to reduce or abolish even one of those various taxes and fees.

Business is business. 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.

This morning, I attended the DOH Advisory Council Meeting on Price Regulation. The above issues were among those discussed. Well, the term "double price control" was not used or mentioned there, it's only a term I coined as I listened to the drugstore owners and managers, including hospital pharmacies, and pharmacists.

The big hospitals were represented there – Makati Med, St. Lukes, Asian Hospital, among others. They 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 develop new diseases, and some of them sue the hospital and their attending physicians.

So the hospital managers 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 and the physician or pharmacist will recommend what dosage to give. Will the new drug price control law allow us to charge additional administrative charges for the medicines we dispense to our patients?" To which DOH officials replied "Yes, a separate charge, but the price of drugs under maximum retail price (MRP) should not exceed the prices as announced."

As a researcher and policy analyst of the effects of various government intervention in the market, I am intrigued by the unfolding of events, even before the actual price control (the second control) will commence.

I have said it before and I will say it again: 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…"

(11) Innovation, competition, and cheaper drugs

September 2, 2009

http://www.thelobbyist.biz/perspectives/columns/back_to_personal_responsibility/innovation_competition_and_cheaper_drugs.html

Innovation is always the engine for change and growth in any individual, enterprise or society. Life becomes interesting and exciting only when there is always something new to see and try, something new to sell and buy, even something new to give away for free.

Innovation is encouraged under a competitive environment. When there is no competition, there is very little incentive to innovate. A monopolist that supplies a particular commodity to a community and it is assured of zero competition for the next 20 or 100 years, will have very little incentive to innovate. Why spend money on expensive research and developing a new and better product when consumers do not have any other options anyway except buy their product no matter how lousy it is?

People change, communities change and evolve. Diseases also evolve. What used to be considered by the people as an ordinary flu is now seen as various strains of flu – bird flu, cat flu, cow flu, swine flu and so on. The attitude of people towards diseases also evolve, they become more demanding if not impatient as they assume that new medicines are coming to cure them within a few days and not a few weeks or months.

The traditional sources of medicine innovation are the pharmaceutical multinational corporations (MNCs). These are huge corporations which have the resources and network to test and develop new drugs to respond to different patients with different diseases with different budget. But more local or nation-based pharma companies are also sprouting up, first to develop off-patent and generic medicines, and later on to start developing their own new concoction and medicines which are both safe and effective.

And still slowly emerging, are individual researchers and non-government organizations (NGOs) which have a clear goal and mission to develop new medicines targeting particular diseases for patients in poorer countries and communities.

Among such innovative and tireless researchers and scientists is Dr. Krisana Kraisintu from Thailand. Krisana is one of the Ramon Magsaysay Awardee for 2009, for being the Champion of Scientific Crusade for Affordable Medicines by “producing much-needed generic drugs in Thailand and elsewhere in the

world." She joined the Government Pharmaceutical Organization (GPO) in 1983 and led its research department in producing many generic medicines for a wide range of illnesses.

In 1995, Krisana produced the world's first generic ARV, a generic AZT (zidovudine) for HIV that reduces the risk of mother-to-baby HIV transmission. In 2002, she left the GPO and went to the sub-Saharan Africa region, hit hardest by the AIDS pandemic. Among the countries she visited and worked with, "In war-torn Democratic Republic of Congo, she set up a pharmaceutical factory that was able to produce generic ARVs after three years." In Tanzania, she upgraded an old facility to produce not only ARVs but cheap anti-malarial drugs as well. The Inquirer has a special news report about her, "RM Awardee: Cheap drugs for poorest".

Krisana's initiatives are good. Those who have the expertise and capacity to produce more competing products made whether by multinationals or local pharma companies, should join the competition. More competition is always good for consumers and patients.

I would add that local pharmas should aspire to become multinationals themselves someday. Like San Miguel, Jollibee, Figaro, SM, and Metrobank, etc., companies that previously were just confined to the Philippines, now selling their world-class products and services in several countries around the world.

Yesterday, I and other NGO leaders under the Coalition for Health Advocacy and Transparency (CHAT), the civil society partner of the Medicines Transparency Alliance (MeTA) Philippines, had a great opportunity to meet up with Krisana. She was joined by the current Director of the Research and Development Institute of GPO, Ms. Achara Eksaengsri.

After an overview of the Philippine health and pharmaceutical situationer given by former DAR Secretary and now President of HealthWatch Philippines, Obet Pagdanganan, we had a productive free flowing discussion. Among the topics that we explored were the following.

One, more competition among pharma companies in Thailand than in the Philippines. In Thailand, there are 167 local pharmas and about 500 multinational pharmas operating. In the Philippines, I could count only about 50+ local pharma and about 40+ multinational pharmas. That's from the members of local pharma association PCPI, and mostly multinationals pharma association PHAP. This partly explains why medicine prices in Thailand are generally cheaper than in the Philippines.

Two, there is no drug price control law being implemented in Thailand, but they have issued compulsory licensing (CL) on 7 drugs against hypertension and cancer. The Philippines has current drug price control program but has not issued CL on any essential drugs yet.

Three, there is no single dominant drugstore in Thailand, unlike in the Philippines where Mercury Drugstore corners a big portion of the drug retailing market. The most dominant player usually could set its own price or profit rate much higher than competing drugstores'. Former Sec. Obet's figure is 60 percent share by Mercury, but I think the steady influx of many new drugstore chains like Watsons and The Generics Pharmacy, plus the in-house pharmacies of private hospitals and clinics, should be eating away the market share of Mercury to only 50 percent or less.

Four, both the Thai and the Philippine governments impose taxes on medicines, despite their high profile pronouncements that they want "cheaper medicines". Thailand has up to 7 percent import tax and 15 percent value added tax (VAT) on medicines. In the Philippines, up to 5 percent import tax on finished products, 3 percent on raw materials, and 12 percent VAT. The latter also imposes VAT on tolling fee which can be claimed as input tax credit against imported drugs' sale of the tolled product, and VAT on the sale of the tolled product to distributors. Then there are import processing fee, import documentary stamp tax, and local government tax. The government charges the 12 percent VAT on the landed price of imported drugs plus the other taxes and fees. The VAT in effect, is a tax on a tax.

To my mind, both governments – and many other governments – are hypocrites for calling for cheaper medicines but contributing to expensive medicines because of the various taxes and fees they impose on medicines. They treat drugs as no different from alcohol, beer and hamburger that must be slapped with as many taxes as possible.

Five, Krisana says the role of NGOs is very important in their work in Thailand in producing alternative cheaper essential drugs, and she believes the NGOs in the Philippines are also playing a crucial role in health policy debates. She calls the Philippines' Cheaper medicines law (RA 9502) "the best" law that she has recently encountered.

I fully agree that NGOs and civil society groups have an important role in various public policy debates, especially in health issues. But said NGOs should not behave or expect like they are adjunct or an "annex" of the government, by easily running to the government to seek for more regulations and interventions.

Here in the country, the President who signed the Executive Order (EO) on drug

price control as pressured by some NGOs and media people, is the same witch that created endless political and business scandals that include large-scale corruption charges, the same witch that wants to be the Prime Minister of the country by attempting to bastardize the Constitution so she will be in power as long as she wants.

NGOs and civil society groups should fiscalize the government in power because even the opposition political parties are not really intent on changing certain policies like medicine taxation because they also want to implement the same regulations and taxation once they are in power. Not a single big politician or political party in this country for instance, has proposed to abolish certain taxes on medicines to contribute to cheaper medicines. Civil society groups should take up that role as voluntary representatives of consumers and ordinary taxpayers.