

## Essays on Politicized Drug Pricing, Part 3

Nonoy Oplas  
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### Introduction

This is the 3<sup>rd</sup> part of my “Essays on Politicized Drug Pricing” papers. [Part 2](#), 25 pages long, was released last December 29, 2009. Papers below were posted or published in (a) my blog, <http://funwithgovernment.blogspot.com>, (b) the online magazine [www.thelobbyist.biz](http://www.thelobbyist.biz), (c) weekend tabloid in southern Metro Manila [People’s Brigada News](#), and (d) other publications (WSJ, Manila Times). I write a weekly column in (b) and (c) above.

There should be some typographical errors in some postings in my blog as I tend to just write down my ideas then click “Publish Post.” So I ask the readers to have patience with such minor errors, and focus on the main arguments. Below are the titles and the dates in 2010 that they were posted:

1. Drug price control and health socialism, January 20
2. Healthcare, rights and responsibilities, January 22
3. Prevention vs. medication, January 27
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9. CL and drug price control, April 20
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Enjoy reading!

## **(1) Drug price control and health socialism**

January 20, 2010

<http://funwithgovernment.blogspot.com/2010/01/drug-price-control-and-health-socialism.html>

While searching for materials on drug price control policy in google, I saw this entry in the LP website, "Roxas: where's the second list?",  
[http://www.liberalparty.ph/news/News\\_LP%202009/second%20list.html](http://www.liberalparty.ph/news/News_LP%202009/second%20list.html)

The article was referring to the Senator's desire to see a second list or second round of drugs to be issued price control. The first list of drugs (21 molecules, nearly 100 drug preparations) was issued in late July 2009. Implementation of drug price control policy was August 15, 2009.

Drug price control, along with IPR-confiscation policies like compulsory licensing (CL), are examples of health socialism.

Price control policy says, "We don't care how excellent and revolutionary your products are. Their price should not be far from the price of the most mediocre products around. Their price should be socialized."

CL policy says, "We non-innovator companies declare upon you innovator companies: the high cost of your R&D and innovation, the losses in your failed researches and unsuccessful products marketed, are yours and yours alone. But your successful and highly saleable invention is also OUR invention."

That's socialism, plain and simple.

I have 3 compilation of my papers on the risks and disadvantages of drug price control policy, writtten over the second half of 2009. For those interested, these are:

1. "Essays on politicized drug pricing, part 2",  
December 29, 2009 (25 pages, 17 short essays),  
[http://www.minimalgovernment.net/media/mg\\_20091229.pdf](http://www.minimalgovernment.net/media/mg_20091229.pdf)

2. "Access to medicines through politics: Preliminary assessment of drug price control policy in the Philippines",  
October 15, 2009 (33 pages incl tables and annexes), presented in a conference in Singapore last October,  
[http://www.minimalgovernment.net/media/mg\\_20091014.pdf](http://www.minimalgovernment.net/media/mg_20091014.pdf)

3. "Essays on politicized drug pricing",  
September 3, 2009 (24 pages),  
[http://www.minimalgovernment.net/media/mg\\_20090903.pdf](http://www.minimalgovernment.net/media/mg_20090903.pdf)

It is dangerous to mix liberalism with socialism. Liberalism in its literal meaning, is to liberate, to free, to remove or limit coercion. Socialism in its literal meaning, is to socialize, to collectivize, by force and coercion.

It is unfortunate, therefore, that a key leader of a Liberal Party that is supposed to advance liberal politics and liberal economic policies, is advocating some populist and socialist policies.

## **(2) Healthcare, rights and responsibilities**

22 January 2010

[http://www.thelobbyist.biz/perspectives/columns/back\\_to\\_personal\\_responsibility/823.html](http://www.thelobbyist.biz/perspectives/columns/back_to_personal_responsibility/823.html)

**The best form of healthcare is preventive, not curative. Among the preventive measures: people should not over-drink, over-smoke, over-eat, over-fight, over-sit in sedentary lifestyle. People should also clean their houses and surroundings and not live in dirty places. Taking vaccines is also one form of preventive healthcare.**

Curative healthcare becomes important in cases of old age, accidents, pediatric diseases, not taking care of one's body, and so on. The best way to do it is through more choices for the public: more private health insurance, more private clinics and hospitals, more pharmaceutical companies, more drugstores, more physicians and health professions – in a competitive environment that compel all of them to improve their services and products continuously. In short, the best way to curative healthcare is through the market. Government role in healthcare should be limited to a few functions like in cases of disease outbreak, and patients with special health needs like those with physical and mental incapacity.

This is not the case in many parts of the world, unfortunately. The dominant thinking which is contained in various public policies, is that “health is a right.” Thus, government should provide this service at a low cost or zero cost, to the public. And such policy should not make any distinction between people who got sick because they are old and weak, or have in-born physical or mental defect, and those who got sick because their internal organs were mutilated by over-smoking and over-drinking, or their heart and blood vessels were choked by heavy fat in their bodies. The government should provide healthcare for all. And since the government has no money of its own, the government should over-tax the public, especially those who take care of their body well, are productive and are earning high.

That is not the only disadvantage of forced collectivized and socialized healthcare, or health socialism for short. The other disadvantage is that such

policy can create “moral hazards” problem or complacency. For instance, instead of smoking one pack a day, two packs should be fine, since government will provide subsidized, if not free, treatment for all.

This is the main topic of a newly-released paper, “Health as a human right: the wrong prescription”, <http://policynetwork.net/sites/default/files/righttohealth.pdf>. The author is Jacob Mchangama, head of legal affairs of a free market think tank in Denmark, CEPOS. Mr. Mchangama wrote,

“The right to health is highly problematic when construed as an enforceable right, with the state legally bound to enforce it in a particular and ideologically skewed manner. It would be better interpreted as a human aspiration whose implementation should be left to the democratic process and be decided upon the basis of the political convictions of the electorate.”

Meanwhile, on January 26-27 next week, there will be a big health forum, the 3<sup>rd</sup> MeTA Forum, sponsored by the Medicines Transparency Alliance (MeTA) Philippines, <http://www.metaphilippines.org.ph/>. The theme of the forum is “Medicines Transparency: a basic human rights issue.”

Among the topics to be explored are medicine procurement in the public sector, PhilHealth coverage for essential medicines, the current drug price control policy, and drugs bioequivalence.

I attended the 2<sup>nd</sup> MeTA Forum last year, and my brief account about the event is here, [http://www.thelobbyist.biz/column\\_detail.php?id\\_article=1055&id\\_category=25](http://www.thelobbyist.biz/column_detail.php?id_article=1055&id_category=25)

On a positive note, there was a good news early this week, “Filipino discovers new vaccine vs. malaria”, <http://globalnation.inquirer.net/news/breakingnews/view/20100119-248174/Filipino-discovers-new-vaccine-vs-malaria>

The Filipino scientist, Rhoel Dinglasan, is an entomologist and biologist from Johns Hopkins University in the US. Dr. Dinglasan’s invention will prevent mosquitoes from spreading malaria if they bite someone who’s been inoculated with the vaccine.

The next questions after this great vaccine invention, are the following:

1. When will this be available for commercial production and distribution?
2. If this will be finally distributed, will the price be affordable and accessible, especially to the poor in poor countries?

3. If it is not deemed "affordable", will this new vaccine be slapped with government policies to make it "affordable", like compulsory licensing (CL) and price control?

While the vaccine is still undergoing further clinical trials and not available to the public yet, humanity will be stuck with old or existing vaccines and treatment against malaria, some of whom may not be very effective. Or the more effective ones are just waiting for some governments' intervention like CL and price control, which makes the inventors and manufacturers of those more effective drugs and vaccines, wary of bringing and selling those products to countries that are likely to be slapped with such government interventions like the Philippines.

In food, there are no government restaurants, no government *carinderia*, no government supermarket, but people are eating. Product differentiation and market segmentation, not forced uniformity, allows the market to develop in all socio-economic classes. The same principle should apply in healthcare. Preventive measures, more personal and parental responsibility and choices in healthcare, more than entitlement from the government and distortionary government policies like drug price control, are the better mechanisms to ensure access to proper healthcare for all.

### **(3) Prevention vs. medication**

January 27, 2010

<http://funwithgovernment.blogspot.com/2010/01/prevention-vs-medication.html>

The “3rd MeTA Forum” is on-going, January 26-27, at Diamond Hotel, Manila. It is sponsored by the MeTA Philippines.

I attended day 1 yesterday, and the topics were some updates on what MeTA International and MeTA Philippines have achieved so far in making medicines become more accessible to the poor. Other topics were procurement of essential medicines by the public sector (DOH-affiliated hospitals, local government units), and financing of such medicines.

There is a long and expanded discussion on medicines, their high prices compared to some Asian countries, the shenanigans in public procurement of medicines, other curative aspects of healthcare. Buried or not even mentioned in the discussions, is the preventive aspect of healthcare.

When people live in dirty places, say under a bridge or a creek with stagnant water, or shrubby areas that attract mosquitoes and various insects, people there, especially children, will be susceptible to various types of diseases. Or when people don't observe proper hygiene like washing their hands well before eating. Or when people over-drink, over-smoke, over-eat fatty food, and so on.

So when people become sickly, the eyes of the public and political leaders are on medicines and the pharmaceutical companies that produce medicines.

Anyway, this is a forum by an organization with explicit and categorical mission to make access to quality medicines be easier to the poor. So we stick to the subject.

What I find rather strange, if not hypocritical, is the continued insistence that various government units, national and local, should be in the business of medicine procurement and distribution to the poor.

Last year in the 2nd MeTA Forum, there was a speaker from WB-Manila who documented instances of many drug warehouses by some big LGUs in the country – where rats, cockroaches, dust and garbage mix up in one room with useful drugs and expired drugs, and the room has no temperature control. In this case, even if we assume that there was no corruption and robbery in drug procurement, the big problem is the quality and efficacy of those medicines that LGUs will distribute to the public.

Yesterday, there was a session where speakers noted that drug procurement prices by government units are several times higher than those in a number of

Asian countries. Which point to either, (a) certain government personnel are bloating their procurement amount so they can pocket and steal more money, or (b) pharma companies here, especially the multinationals, tend to price their products a lot higher in the Philippines than in other Asian countries. Or both happened.

If the main explanation is (a) above, then it's one clear case of government failure, happening persistently. Then there should be some persecution of guilty parties in order to send a strong signal to other government personnel that stealing is heavily penalized, not forgotten. Then corruption in public procurement will be drastically reduced, if not controlled.

If the main explanation is (b) above, then it's one clear case of the lack of competition among pharma companies, foreign and local. One policy implication is to encourage the entry of more players, both foreign and local, both manufacturers and traders (wholesalers, retailers).

Sadly, public policy actions in either (a) or (b) are not being done. Public procurement continues, foreign loans by the WB and other foreign aid institutions continue, poor health outcomes in the public continue, and endless taxation to pay for ever-rising expenditures and public debts on drug procurement and related healthcare items, continue.

So what is the result, the state of public health, especially the poor people, remains generally unchanged while public debts and taxes keep rising?

#### **(4) Uncontrolled passion for price control**

30 January 2010

[http://www.thelobbyist.biz/perspectives/columns/back\\_to\\_personal\\_responsibility/824.html](http://www.thelobbyist.biz/perspectives/columns/back_to_personal_responsibility/824.html)

**Price control is price dictatorship. Or one form of product coercion, or industry over-regulation.**

There are many factors why the price of a particular commodity or service is deemed “expensive” and “inaccessible”, especially to the poor. Foremost of which are (a) cost of production, including the cost of innovation and R&D, (b) cost of marketing and promotion, (c) cost of transportation, storage, distribution and retailing, (d) cost of taxes and regulatory fees by governments (national and local), (e) mark-up by producers and traders, depending on the extent of competition among suppliers and producers. Absence of any competition (monopoly) or just limited competition (oligopoly) means bigger mark-up.

Very often, government regulations directly or indirectly, determine the extent of competition or lack of it, in a particular industry or sector. Government franchising, for instance, creates monopolies. An electric cooperative, or a cable tv operator in a particular province or region, or tricycle route in a particular village or municipality, are given monopoly franchise by certain government agencies.

The drug price control policy is now five and a half (5 ½) months old since its implementation last August 15, 2009. There has been no serious study or assessment made by the implementing agency, the Department of Health (DOH) yet, on whether the policy has attained its primary objective – to make branded, popular and highly saleable medicines produced by multinational pharmaceutical companies, become more affordable and more accessible to the poor.

And yet, there are policy pronouncements by the DOH to issue another round of price control. Like this news report, “Therapeutic drug price cut considered”, January 28, 2010, <http://www.bworldonline.com/main/content.php?id=5329>

A Singaporean physician has written a number of observations about this Philippine government policy. The latest of his discussion was “The ultimate domino effect of ignorance”, January 28, 2010,

<http://www.whitespacelab.com/2010/01/28/the-ultimate-chain-reaction-of-ignorance/>

On the proposed round 2 of drug price control by the DOH reported in the news story above, the occasion was during the 3<sup>rd</sup> Medicines Transparency

Alliance (MeTA) Philippines Forum this week, January 26-27. I have attended the 2-days forum held at Diamond Hotel in Manila. Drug price control, aka maximum retail price (MRP), was extensively discussed in the morning session of day 2, last January 27. The five speakers in that panel were leaders from the Cancer Warriors Foundation (CWF), Health Action Information Network (HAIN), Philippine Chamber of Pharmaceutical Industry (PCPI, the alliance of local pharma companies), the European Commission Technical Assistance - Health Sector Policy Support Program (ECTA-HSPSP), and Philippine Health Insurance Corporation (PhilHealth).

Drug price control is explicitly supported by the CWF leader, was deemed “important but not enough” by the leaders of HAIN and ECTA, was shot down by the PCPI leader, while the PhilHealth official has some preliminary but incomplete assessment of the policy yet.

Succeeding discussions during the open forum showed that the price control policy rests on a hollow base. A speaker from a medium-size drugstore chain, for instance, said that contrary to expectations that the volume of branded medicines by multinational pharmaceutical companies that were hit by the policy will increase, the lady said that their sales of such medicines even suffered a decline of 3 percent from mid-August 2009 to late January 2010. And why is this so?

It is because those who used to buy the affected drugs did not increase their purchase of said products. If they were taking one tablet per day, a 50 percent mandatory price cut did not cause them to buy two tablets per day. They just saved money. Meanwhile, the poor still found the 50 percent price cut not enough. Take amlodipine (most popular, branded drug is “Norvasc” made by Pfizer). Before the MRP, it was sold at Php44 per tablet. But the cheapest generic amlodipine, same dosage, was already selling at Php8 per tablet. So even at coercively reduced price of Php22 per tablet, it is still expensive for those who get another drug for the same disease at only Php8, or even Php11 per tablet.

In short, MRP benefited the rich and middle class, not the poor, who are the main target beneficiaries of the policy. Competition among pharma companies in the country made sure that poorer households and patients would have some alternative drugs at a lot cheaper price compared to branded and patented drugs. Besides, pharma industry leaders (both multinational and local) who spoke during the forum, pointed out that some small, local generic manufacturers whose drug prices are only about 70 percent lower than the branded products prior to MRP, suffered erosion of their market share as some of their customers shifted to the branded drugs that experienced mandatory price cut of 50 percent.

An official of another medium-size drugstore chain that I talked to said that their sales showed some increase in the volume of the branded drugs by

multinational companies that were hit by MRP. Thus, local generic manufacturers were also badly hit by the policy. All drugstore managers (both chain stores and independent small ones) that I talked to during the forum said their sales as drugstores were badly hit too. Since they were advised by the DOH to keep their percentage mark-up, say 10 percent, before and after the MRP, their profit was affected. At 10 percent mark-up, they make Php5.00 gross profit from a drug selling at P50. When that drug's price was forced by the government to be sold at only Php25, now they make only Php2.50 gross profit. And since drugstores are also forced by two laws to give mandatory 20 percent discount to (a) senior citizens and (b) persons with disabilities, the small mark-up they make from average customers can be wiped out by the mandatory 20 percent discount that the government mandated that drugstores alone should shoulder.

The uncontrolled passion for price control may be understandable if the intended target beneficiaries indeed benefit. But if it did not, such uncontrolled passion is no longer guided by the logic of economics and healthcare for the many. It is simply guided by politics and the deep desire for strong power to regulate other people's lives and business.

## **(5) Cheap but not available**

February 03, 2010

<http://funwithgovernment.blogspot.com/2010/02/cheap-but-not-available.html>

During the 3rd MeTA Forum last week, presentation by Dr. Delen dela Paz of Health Action Information Network (HAIN) and also a faculty member at the UP College of Medicine, she mentioned one result of the HAIN medicines survey in 2009: essential generic drugs' prices in public drugstores are about 1/3 than prices in private drugstores. So many poor people go to government-run or sponsored "botika". Problem is that availability of such cheap drugs were only 31% in public outlets vs. 61% availability in private drugstores.

So, the hard lesson: cheap, yes, but less or not available.

Which is better: more expensive but available vs cheap but not available? If one is very sick, then price becomes a secondary issue compared to availability of a product that can make him/her well.

And this is one long-term effect of drug price control that advocates of the measure, including those in the government, seem not to realize: more effective drugs, more disease-killer medications, will theoretically be sold "cheaper" in the Philippines. But their availability is zero. Manufacturers and sellers of those drugs will sell such products in Singapore or Hong Kong or

Japan or other Asian countries which have no drug price control policy, and not bring such products in countries where a price control is being implemented, or pulled out but can be re-implemented anytime, depending not on any health emergency, but on certain political emergencies of the big politicians and the administration in power. So desperate patients will be forced to purchase such drugs abroad, at a more expensive price because of the cost of shipping and storage.

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Also during the MeTA Forum, MeTA Philippines leaders gave a press conference on day 2 (January 27). Dr. Alberto Romualdez, former DOH Secretary and currently MeTA Philippines chairman, said that "More than half of the country's annual expenditures for health products ranging from P100 billion to P150 billion are unnecessary because they hardly provide any therapeutic effect", see here, <http://www.philstar.com/Article.aspx?articleId=544389>

This is related to "irrational drug use" issue. People are buying medicines and vitamins even with little or no proven therapeutic effect simply because such drugs are cheap, or are heavily advertised (broadcast media, outdoor billboards, etc.).

One big local pharma company is the heaviest spender on drug advertising in the country.

## **(6) Boycott medicines**

February 04, 2010

<http://funwithgovernment.blogspot.com/2010/02/boycott-medicines.html>

After the 3rd MeTA Forum last Jan. 26-27, we have a forum for our local coalition, Coalition for Health Advocacy and Transparency (CHAT) last Jan. 28, also at Diamond Hotel.

I jokingly told some friends and other NGO leaders there that one of my personal advocacies is not cheaper medicines but "boycott medicines". This is somehow an offshoot of MG philosophy, "Healthcare is first and foremost personal and parental responsibility." Why?

The full year 2009 and last month, or 13 months straight, I have not been taking any medicine -- no vitamins, no food supplement, no anti-biotics, etc. For me, the best medicines are good food, nutritious food. And not abusing one's body. I drink, about 2 to 3 times a month. Mostly light drinking, but sometimes heavy drinking with heavy head and hang-over the next day :-). But I don't smoke.

Last month, because of the cold season, I got a cough, which lasted for about a week. The physician in our HMO suggested that I take anti-biotics since the cause of my cough was bacterial. Here's our brief conversation:

Me: Doc, is drinking not allowed while I take the anti-biotics drug?

Dr: Yes!

Me: But I got an invite for a belated reunion with some friends tonight, with lots of food and beer!

Dr. You choose, ridding your cough quick or your beer.

After leaving the HMO office, I said I will just buy the drug tomorrow and I will choose good food and beer tonight. I just drank lots of water and juice, and beer that night.

The next day, before going to the drugstore to buy the anti-biotics, I got a text message from another friend, "Please be there on my birthday party!" That's just 2 days from now, and I know that this friend of mine always gives slam-dunkin birthday bash, with unlimited food, unlimited drinks (beer, wine, high-octane drinks, etc.). So I said, I will postpone buying the drugs for another 2 days.

Meanwhile, I continued the "water therapy" -- lots of water, juice, other liquid. It's discomforting sometimes to be going to the toilet so often to pee, but that's the result if one drinks lots of water too often.

So enjoyed the night during my friend's birthday party. Super-enjoyed that I got a bad hang-over the next day. But surprisingly, my "water therapy" was working well. Although I had a hang-over that day, my cough was getting weaker. A few days more of lots of water intake, the cough was gone!

Lesson? I did not buy the essential drugs not because I don't have the money, but because I chose beer on those 2 occasions in a span of 4 days that I was advised by my doctor to take anti-biotics!

Not taking medicines for the wrong reason :-)

But seriously, the best medicines are good food, nutritious food, and not abusing one's body with over-drinking, over-smoking, over-eating, over-fighting, over-sitting in sedentary lifestyle, etc.

When real diseases come in, say hypertension or cancer or other serious diseases, that's the time to buy prescription drugs. By then, one has a somehow healthy body and some savings to buy the necessary medication. And don't forget, the physician's fee and diagnostic tests, if one does not have a private health insurance.

## **(7) Second round of politicized drug pricing**

March 02, 2010

<http://funwithgovernment.blogspot.com/2010/03/second-round-of-politicized-drug.html>

Last Friday, February 26, this was the headline in the DOH website,

"DOH announces second wave of drug price reduction",

<http://www.doh.gov.ph/node/2597.html>.

Four days before that, February 22, there was a meeting by the DOH Advisory Council on Price Regulation, and one of the main topics that day was about the 2nd list of drugs where prices were voluntarily brought down by their manufacturers. I attended that meeting, that's why I knew about this.

A few points about the DOH announcement, above.

One, there is the impression that the foreign pharma manufacturers just brought down the prices of their products almost simultaneously. I gathered from some sources that the DOH leadership wrote to the officials of foreign pharma companies in the Philippines, asking for a new round of drug price cut. In short, there was a prior request from the DOH.

Two, one official of a big Filipino-owned pharma company noted that the DOH only wrote to the foreign manufacturers, but not to the local pharma companies. He said that locals have some capacity to bring down the prices of some of their medicines. So should the DOH advertise later those drugs and their new prices, the foreign manufacturers that participated in that price cut will receive some favorable feedback from the public.

Again, there is no need for such DOH action of writing to the foreign pharma companies for possible price discount if there is healthy competition among the players. No need for DOH letter, then press release on the subject, no need for DOH to deputize the Food and Drug Administration (FDA) to ensure that drugstores nationwide will indeed implement the 2nd round of drug price cut.

## **(8) Health is a right, health is personal responsibility**

March 03, 2010

<http://funwithgovernment.blogspot.com/2010/03/health-is-right-health-is-personal.html>

(This is my article for "People's Brigada News", a Pasay city-based tabloid, last February 19, 2010.)

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The concept of "Health is a basic human right" is popularly supported by many people. Both for its emotional appeal and for some international agreements, like the International Covenant on Economic, Social and Cultural Rights.

A sub-set or sub-topic then are the formulations, "Access to medicines is a basic right", "Access to hospitals and healthcare is a basic right", and so on.

Thus, others would extend them further and say, "Education is a basic human right", "Decent housing is a basic human right", "Cheap and abundant food is a basic human right", and so on.

The term "right" implies and connotes entitlement. That is, regardless of the circumstances why one person or household or community has/have become sickly, they should be entitled to decent healthcare to be provided at a low cost if not free by the government, local or national.

This can be a big source of public debate between those who demand entitlement and those who question it. For the latter, for every "right" there is a concomitant "responsibility." Thus, while people can demand that health care is their basic right, they are also expected to assume certain responsibilities about their bodies and their lifestyles

I personally believe that healthcare is first and foremost, a personal and parental responsibility. People should not over-drink, over-smoke, over-eat, over-fight, over-sit in sedentary lifestyle. People should not live in dirty places and should observe basic personal hygiene like washing hands carefully before eating.

Health inequity results not just because of income and social inequity, but also because of people's unequal inputs in taking care of their body. A person may be poor but if he does not over-drink and over-smoke and observe personal hygiene in his daily life, he will have a better health outcome than a rich person who over-drinks, over-smokes, over-eats and over-sits. The former, even without a private health insurance, all other things being equal, will less likely develop lifestyle-related diseases like hypertension, high cholesterol and obesity.

These topics are timely as the drug price control policy of the government is now more than six months old, and there is no formal assessment made by the Department of Health yet, on whether it has achieved its goal or not – to make essential but deemed expensive medicines become more affordable to the poor.

In the absence of such formal study and assessment by the DOH, some sectors and industry players – drugstore operators, pharma companies, some NGO leaders – have already produced their own findings: the answer is No. The policy, supposed to help the poor, did not benefit the poor.

The main reason is that there was a relatively healthy competition among pharma companies in the country already, among innovator companies and among generic producers. So while the rich and middle class were looking at a branded amlodipine, for instance, at P44 per tablet, there were cheap amlodipine generics already, sold as low as P8 per tablet. When price control was imposed, the P44 became P22. But the poor did not buy the P22 a tablet, because it is still high compared to what they are buying at P8 a tablet. So the poor did not benefit, the rich and middle class did.

Instead of forcing private companies to give the discounts, the government should force itself to procure essential medicines at no-corruption price and dispense these for free to the really poor, especially children of poor households who have been exposed to dirty environment for several years, who now have weaker lungs and other internal organs. This is where government can possibly put its limited resources – giving essential medicines for free to these patients.

The best form of healthcare is preventive, not curative. People should not abuse their body simply because alcohol, tobacco and fatty foods are more available and more affordable compared to several decades ago. But should they abuse their body, then they should suffer some consequences later.

Meanwhile, the damage to the country's investment environment as a result of no-time table drug price control policy should be big by now. Many revolutionary drugs, new disease-killer drugs that are available in other countries around the world, may no longer be introduced and sold in the Philippines. The most adversely affected then will be the poor and some middle class patients. The rich, the politicians and government administrators who pushed the price confiscation policy, will have the means and network to buy such drugs from abroad.

That is one example of the “law of unintended consequences.”

## **(9) CL and drug price control**

April 20, 2010

<http://funwithgovernment.blogspot.com/2010/04/cl-and-drug-price-control.html>

During the Coalition for Health Advocacy and Transparency (CHAT) forum last month assessing the cheaper medicines law (CML, RA 9502), some friends and fellow NGO leaders argued that price control of off-patent drugs is not effective because there are competitor generics available already which are a lot cheaper even if innovator drugs' prices have been slashed to one-half. Then they added that price control should be imposed on patented drugs, where there are no generic competitors yet, in order to force their prices down.

This logic is questionable. A friend and health NGO leader added with the following arguments.

"The multinational drug companies have always threatened a pull out of their products if they do not get what they want, but they have never really done it. In this case, with compulsory licensing or parallel import or government price control of drug prices, they can always threaten us again. They can again give the same threat but I doubt if they will really implement it because they will not take the risk of losing the huge amount of profit that they are amassing in the Philippines.

... the government should stand firm in its position of lowering drug prices. If the drug companies pull out, then we can do parallel importation. It is about time that we show these drug companies that we are not afraid of their threatened pull out. We should not be made hostage to their ploy.

Thus, patent protection for drugs should really be shortened so we are not dependent on these foreign companies for so long. We should develop our own drug industry as soon as possible and encourage healthy competition among local drug manufacturers."

Yes, we all want cheaper medicines. My father is 82 yrs old and is practically dependent on medicines. My mother is 75 yrs old and is totally dependent on her weekly injection for her kidneys, for life! My wife has hypertension and is dependent on maintenance drugs. My elder brother died of prostate cancer, my sister in law died of colon cancer.

I am lucky that I don't get sick, except on Dec or Jan where I get nasty cough because of the cold weather and holiday parties.

My parents are lucky to get 20% senior citizen discount on their drugs, but at xx thousand pesos per month of medication, it's still pocket-draining.

So competition among innovator companies and among generic manufacturers is really helpful. But government's continued taxation of medicines does not help. At 5% import tax + 12% VAT + regulatory fees (FDA, etc.) + local govt taxes, they all contribute to expensive medicines.

Here are some of my rejoinders.

If any of those multinationals will get out of the country, not just their products but their offices, then only traders and importers will bring in their products, new and old. The term for that is plain importation. The term "parallel importation" applies only if the (pharma) company has an office here, imports their patented drugs from their regional or global HQ at a high price. Then comes another company that will import the same patented drugs from other countries without the permission of the patent holder and sell at a lower price. That's why it is called "parallel" importation. In Filipino, "magkatabi" or "magkasabay na importasyon."

The best way that I can think of developing "our own drug industry" is to allow United Lab, Pascual Lab, other domestic pharma, to flourish and become multinationals themselves, exporting their drugs at least to other Asian countries. Let us not push the idea of the DOH or the Office of the President (OP) putting up a government pharma company like Thailand's GPO as the fiscal cost of such project will be too high. If the DOH cannot operate a big government hospital with full efficiency, what makes us think that the DOH can operate a big pharma company?

I sincerely wish to see local pharma companies become multinationals themselves. SMC, Jollibee, Figaro, Metrobank, SM, etc. are now big multinationals abroad. The cost of pharmaceutical R&D is so big, that only big companies will have the resources to do such job with full accountability. Meaning, if a local pharma company will sell its new line of innovator drug and some adverse results happen to patients and it gets sued, such local pharma company will have the resources to tackle both scientific and legal battles at the same time.

## **(10) Medicinal elections**

24 April 2010

[http://www.thelobbyist.biz/perspectives/columns/back\\_to\\_personal\\_responsibility/841.html](http://www.thelobbyist.biz/perspectives/columns/back_to_personal_responsibility/841.html)

**Health financing and medicine prices are among the topics that would crop up during debates among opposing candidates and political parties as the national and local elections are just a few days away. Candidates tend to embrace the more interventionist, more confiscatory policies to become more popular with the voters. Among the populist promises made by national politicians are (a) extend and expand the drug price control policy, and (b) the state confiscating drug patents to further bring down prices.**

Let us expand this into a hypothetical but probable scenario.

Let the Department of Health (DOH), upon the prodding of some influential legislators, extend drug price control, impose compulsory licensing (CL), and push parallel importation, to all patented drugs in the country. Do all three policies simultaneously, since these policies are now legal and allowed under the Cheaper Medicines Law (RA 9502) under certain conditions, and many people think that patented drugs = expensive = anti-poor.

With the high cost of inventing more powerful drugs, the innovator pharmaceutical companies will stop selling their newest drugs, their more disease-killer drugs into the country. They say,

"The most effective anti-hypertension drugs in the Philippines right now can bring down blood pressure in 1 hour or 30 minutes. Our new drug can do that job in 5 minutes, zero complication.... Or current anti-cancer drugs available in the Philippines can give an average patient some 20 to 30 percent survival chance. Our new anti-cancer drug can improve a patient's survival chance from 50 to 60 percent.... But you can not buy our drugs in any Philippine drugstore. You have to buy them in Hong Kong or Singapore Japan and other Asian countries with no price control, no CL." or

Is this a good and desirable situation?

Other people will say "Nothing to worry, multinationals have threatened in the past to pull out of the country, or pull out some of their products in Philippine markets if they will not get what they want. But they never did so since they still make lots of profit here. And patents have to be shortened as much as possible because 20 years patent is too long for profit-making. Patients over patents."

This answer is not plausible for the following reasons.

**One**, there is no need to "pull out" newly patented, more expensive, but more disease-killer drugs from the country because the innovator companies, as mentioned above, will not make them available here in the first place. They will only bring in their off-patent, or patent expiring in 1 to 2 years, but not the newly-patented with 7 years or more patent life.

**Two**, the 20 years patent is only on paper. There are plenty of regulatory approvals AFTER a patent has been filed and approved, and regulatory scrutiny is increasing, not decreasing, around the world. Meaning, the patent starts from the discovery of the molecule, before undergoing various clinical trials, and not from the time the drug is marketed. Innovator companies say that of the 20 years patent life, the effective patent protection and "commercial or profit period" is only about 7 to 11 years because the first 9-13 yrs are spent on various clinical trials (from animals to people) and complying with various regulatory procedures by food and drugs administrations (FDAs) of governments.

**Three**, any adverse result to people that will occur during clinical trials which the innovator company cannot find a solution, then that drug will be abandoned for commercial development, even if several million dollars have been spent already, even if that molecule has a patent already.

There are proposals also that the government should put up its own drug industry, similar to Thailand's Government Pharmaceutical Organization (GPO). The best way that I can think of developing "our own drug industry" is to allow United Lab, Pascual Lab, and other domestic pharma companies to flourish, via joint ventures with other big local Asian pharma companies (say from India, China and Pakistan) and become innovator multinational companies themselves, exporting their new drugs to other countries.

Let us not push the idea of the DOH putting up a government pharma company as the fiscal cost of such project will be too high. If the DOH cannot operate a big government hospital with full efficiency, what makes us think that the DOH can operate a big pharma company?

Many people never tire of citing "market failure" in health and other sectors. What they do not realize is the huge distortions created by bigger government intervention and taxation. At 5 percent import tax + 12 percent VAT + FDA regulatory fees + normal corporate taxes + local government taxes, government contribution to expensive medicines is often overlooked.

More competition, not more government regulation and taxation, will bring down medicine and healthcare costs over the long term.

## **(11) Cancer and politics**

12 June 2010

<http://funwithgovernment.blogspot.com/2010/06/cancer-and-politics.html>

(Note: this is my article for [www.thelobbyist.biz](http://www.thelobbyist.biz), June 12, 2010)

**Cancer is among the top killer diseases in the world and in the Philippines. Personally, this disease is impossible to brush aside because a number of people close to me have died of it.**

My elder brother, the eldest in our family, died of prostate cancer a few years ago. His wife and my sister in law, died of colon cancer several months before him. My mother's first cousin in Cebu also died of prostate cancer. One of our wedding godmother died of cancer early this year. Another godmother is undergoing chemotherapy with a rare type of cancer.

The latter is very close to us, especially to my wife. News of her having a cancer made us very sad. But news that she is fighting back and doing well also cheers us. Sometimes she is weakened and has to be hospitalized, on most days she is doing well and following the medications given by her physicians. Nonetheless, we only wish that the cancer cells in her body will be gone and defeated, we wish nothing less than that.

Thus, I really wish that this killer disease will be killed someday too, or be significantly neutralized and controlled. The role of innovator pharmaceutical companies is important here because they are the only ones – not the generic manufacturers, not the tobacco or alcohol or automobile or energy companies – which do serious and very costly research and development to find more powerful, more disease-killer drugs and vaccines.

While some cancer cases are due to genetics, many cancer cases are lifestyle related. Like lung cancer due to over-smoking and liver cancer due to over-drinking. Thus, the first defense or “cure” against the latter type of cancer is to have healthy lifestyle. This highlights our main argument explained several times in this column, that health is first and foremost, personal and parental responsibility, not government responsibility.

Once cancer cells have grown, whether due to genetics or unhealthy lifestyle, the next line of defense will be by medications and physician intervention. It is important of course, to keep – or go back to – healthy lifestyle in order to help keep one's body have stronger immune system.

When medications and medicines come in, that is where politics also come in. The immediate concern of many sectors in society, especially the health NGOs, patient groups, media, politicians and other political groups, is to pressure innovator pharmaceutical companies to significantly bring down the price of their new, more powerful, more disease-killer, but still patented drugs.

The fact that all innovator companies are multinationals and are based in rich countries make them even more “devil-looking” in the eyes of such activist groups.

That there is huge cost in both actual R&D work and in complying with various requirements of various government drug regulatory agencies like the Food and Drug Administration (FDA) is less important to the different activist groups. The point is to use politics and political pressure to demonize the innovator companies. There are several tools to achieve this, like compulsory licensing (CL), parallel importation and drug price control. CL on some anti-AIDS and anti-cancer drugs has been used by the government of Thailand while the outgoing Philippine government has used drug price control for a number of drug molecules ranging from anti-hypertension, anti-cancer, anti-cholesterol, antibiotic, anti-diabetic and anti-thrombotic.

The high cost of new medicines is indeed a valid issue. This is no different from the higher prices of new models of mobile phones, flat tv, laptops and cars. New models are seen to be more revolutionary and contain qualities that are more powerful than the older models. But the availability of new and more powerful drugs and vaccines is sometimes a more basic issue than their price. There are many drugs that are deemed powerful but are not found in drugstores.

Desperate patients and their families and friends are willing to forego certain material things in their lives – like selling the second car, selling other properties – just to save a beloved person’s life. For this type of people, the price of more powerful drugs is secondary to their availability. The typical argument is that they can earn money later on, but they cannot bring back to life once a beloved person and friend has died.

Politics should step back in areas where science and medicine have the dynamics and incentives to find treatment to killer diseases. Where there is profit to be earned in this sector, more pharmaceutical, biotechnology and research companies will sprout and compete with each other in developing more powerful drugs and treatment to cancer and other killer diseases. The public’s desire for more powerful but more affordable drugs will be assured by a healthy competition among innovator and research companies. Once the patent has expired, the next line of competitors, the generic manufacturers, will further introduce off-patent drugs at a lot lower price.

The important thing is that new, innovator drugs from innovator companies should be allowed and encouraged to come on stream regularly. Patients’ lives are more important than politics.

## **(12) WSJ article on drug price control**

June 22, 2010

<http://funwithgovernment.blogspot.com/2010/06/ws-j-article-on-drug-price-control.html>

About 2 weeks ago, I got a call from James Hookway of WSJ in my cp. He said he read my papers and presentation materials on drug price control from the MG website. Below is his news report, I was quoted in one paragraph there.

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<http://online.wsj.com/article/SB10001424052748703340904575284061202593520.html>

Wall Street Journal  
JUNE 18, 2010

### **Philippine Price Controls Hamper Rise of Generics**

By JAMES HOOKWAY

MANILA—The Philippines recent embrace of drug-price controls to lower the cost of life-saving medications is creating some unexpected problems—including crimping the supply of inexpensive generic drugs.

The country's president, Gloria Macapagal Arroyo, was eager to reduce the cost of pharmaceuticals in a nation where a third of its 95 million citizens live on around \$2 a day. Last August, she used new regulations to cut the cost of five widely used medications, including Pfizer Inc.'s Norvasc hypertension drug and GlaxoSmithKline PLC's Augmentin antibiotic.

Facing mandatory price cuts, drug companies in the Philippines cut the prices of an additional 16 drugs, and in February agreed to slash the prices of frequently prescribed medicines.

A pharmacy customer in Manila.

Industry analysts and executives said the price caps have unintentionally knocked the wind out of a nascent generic-drugs industry that had sprung up here. Lower-priced brand-name drugs are pressuring these low-cost producers, and creating a policy challenge for President-elect Benigno Aquino III, who takes over at the end of June.

Edward Isaac, executive director of the Philippine Chamber of the Pharmaceutical Industry, said price controls and the threat of more caps have lowered the cost of some brand-name drugs to near those of generic

competitors. Pfizer's Norvasc was cut to about 22 pesos, or 47 cents, for a five milligram tablet, from over 44 pesos.

"What's happening now is that when the price of Norvasc, for example, is cut, the generics have to slash their own prices," Mr. Isaac said.

Declining profits have some drug retailers putting expansion plans on hold. "We've not opened any new stores since the price controls were introduced," said Leonila Ocampo, vice president of Manila-based MedExpress. The drugstore chain has seen sales volumes drop since the price controls were introduced. "Our margins are under pressure, and if there's no profit, I don't know what will happen," said Ms. Ocampo.

Another drug store operator, Florecita Intal of Stardust Drugs & Medical Supplies Corp., said lower revenues from the branded-drug price caps restricts her ability to expand and offer less expensive generics. She fears smaller retailers might not survive.

While brand-name drugs still account for a large proportion of the drugs market here, generic competitors were beginning to gain in popularity, driven by the spread in recent years of generics-based chain stores up and down this densely populated country.

Data collected by Mr. Isaac's organization indicate, however, that the value of all drugs sold dropped 15% from August 2009 to February 2010, while the volume of pharmaceutical sold here held steady.

Bienvenido Oplas, head of the Manila-based Minimal Government Thinkers Inc. think-tank and a member of the consultative panel advising the Philippines' Department of Health, said this means the price controls policy just isn't working. "It hasn't fulfilled its objective of making more drugs available to more people," he said....

## **(13) Using game theory in analyzing drug price control**

08 August 2010

[http://www.thelobbyist.biz/perspectives/columns/back\\_to\\_personal\\_responsibility/883.html](http://www.thelobbyist.biz/perspectives/columns/back_to_personal_responsibility/883.html)

**If there is free competition among companies and players, there will be dynamic and fluid changes in pricing and marketing of products by the players. Such changes can happen within months or weeks, or even days, as each player is watching its competitors' current and future moves.**

If free competition is hampered or killed by government intervention like drug price control, such fluidity is also hampered. Both foreign and local players will be watching not much each other, but the government. They will be asking questions like: How long will the drug price control stay? Will the list of drug molecules under price control be expanded or reduced? Will there be other interventions aside from price control?

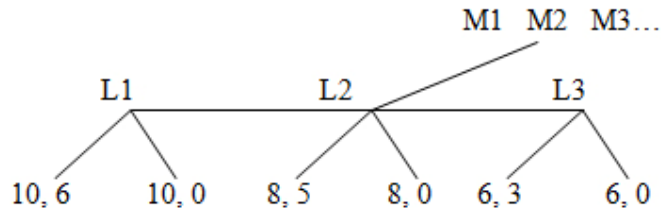
The more that such questions are not answered, the unstable the business environment in the sector will be. More instability means weaker competition and weaker attractiveness of the economy to other potential players, both foreign and local. And this will negatively affect the competitiveness of the sector and the economy over the long-term.

Game theory is an applied mathematics theory adapted in the social sciences and economics. It is useful in analyzing players and consumers' behavior, which can help guide public policy.

In the pharmaceutical industry, there are many players. Let the multinational pharma companies be labeled as M1, M2, M3, and so on. And let the local pharma companies be labeled as L1, L2, L3, and so on.

When the government imposed the mandatory 50 percent price cut on the best-selling products by some big multinational pharma companies last year, this greatly affected not only the multinationals but the local players as well.

Companies M1, M2, M3 and so on halved their prices, say from P20 to P10, from P16 to P8, from P12 to P6, respectively. Assume that the prices of companies L1, L2, L3 and so on are 40 percent lower on average, than the original prices of the multinationals. So L1, L2, and L3 will have two options: further price cut of their already low-price generic drugs, or withdraw some products, at least temporarily while price control is in effect, if there is no more room for further price cut without suffering significant losses. The result may look like this:



The figure (10, 6) means the after-price-control price of M1 is P10 while L1's price is P6. The figure (10, 0) means M1 keeps the P10 price while L1 has withdrawn its product. In which case, the local generics manufacturers were whacked by the government's price control policy.

From the various data coming from medium-sized drugstores in the country, it seems that the market was distributed to (10, 6), (8, 5) and (6, 3) situations. For the ABC class of consumers, there was a big switch from generics to the branded drugs that were under price control.

Did the poor benefit from such downward price spiral? A number of data say that the answer is NO. Take the molecule amlodipine, an anti-hypertension drug. The most popular brand then was Norvasc, made by Pfizer, sold at P44 for the 5mg tablet. Prior to price control, the cheapest generic was sold at only P8. After price control was imposed, the P44 became P22, but for the poor, it is still expensive since the cheapest generic producer has retained its P8 price, or possibly brought it down further.

For the really poor, the most affordable price is not 50 percent of xx pesos, but zero. The poor want the essential drugs to be given to them for free.

For those with sentiments that the price control policy should cause pain and losses to the "profit-hungry capitalist multinationals", the above exercise in game theory says there is a "law of unintended consequences" and that those who were possibly hurt more, are the local pharma players L1, L2, L3 and so on.

If arm-twisting companies M1, M2, M3 and so on to bring down their prices did not succeed in improving access of the poor to essential branded medicines, then the next option for the government is abandon the policy, and shift to bulk purchase of those essential medicines, the cheaper generics especially, and give away to poor for free. Some pharmacists would caution though that giving away drugs for free should be under professional supervision. Irrational drug use, if not unhealthier lifestyle among the poor, can be encouraged by free medicines. And irrational drug use will create new health problems in the future.

## **(14) Drug price control: 1 year of failure**

<http://funwithgovernment.blogspot.com/2010/08/drug-price-control-1-year-of-failure.html>

(Note: This is my article for [People's Brigada News](#), submitted last August 11, 2010)

This August 15, the drug price control policy will turn exactly one year old. The government, through the Department of Health (DOH), imposed a 50 percent mandatory price reduction for many branded drugs that it deemed were essential but expensive. Let us see some results of the policy.

Medium-sized chain MedExpress and Manson drugstores reported some chilling sales data. From August-December 2009, all the price-controlled drugs suffered a 3.4 percent decline in volume and 34.3 percent decline in sales value, compared to August-December 2009. Comparing January-May 2010 with January-May 2009, sales volume of the price-controlled drugs has managed to post an average of 7.3 percent, but sales value has declined by an average of 65.4 percent.

The sales value decline is bigger than the 50 percent forcible price reduction because there are other mandatory discounts that the government has imposed on drugstores on top of the 50 percent mandatory price cut, like 20 percent mandatory discount for both senior citizens and persons with disabilities (PWDs).

There are a number of reasons why the drug price policy failed. Four reasons stand out.

One, the policy was driven mainly by politics and not by any national health emergency. A former Senator running for President but lagging in Presidential surveys pushed hard the issue some 12 to 13 months before the May 2010 elections. A very unpopular President serving the last of her 9 years in office rode on the emotional popularity of the measure.

Two, competition among innovator drugs and generic drugs was already dynamic prior to the price control measure. Take amlodipine molecule for anti-hypertension. The most popular drug was Norvasc 5mg, selling for P44 a tablet. Then it became P22. But the cheapest generic available prior to price control was selling for only P8. The poor who buys the latter drug finds the P22 still a lot more expensive and hence, will not buy it.

Three, the policy has the unintended consequence of hitting the local pharmaceutical companies that produce the competing generic drugs. They were pushed to further bring down their already low prices.

Four, some small and independent drugstores were forced to further cut their personnel and other cost of operations just to survive, or close shop altogether. Which contributed to more unemployment in the country.

It is important that the government should focus on encouraging competition among various drug manufacturers, among importers, drugstores and hospitals. The new President should signify that the government will not entertain another round of drug price control in the next six years of its term. This will help improve the investment environment in a country that badly needs more investors and job creators.

## (15) Medicines, innovation and pricing

August 13, 2010

<http://funwithgovernment.blogspot.com/2010/08/medicines-innovation-and-pricing.html>

It is good to find a physician with a good grasp of economics and finance, and thus can write well on health policy issues. One such physician that I have read is Dr. Tej Deol of **Asia Health Space**

In his recent long article, [Little red riding hood \(society\) and the big bad wolf \(branded pharma\)](#), Dr. Tej discusses about certain expectations that pharma companies should sacrifice something for society. It is a philosophical-economics-innovation paper, well-written.

The author wrote for instance, about the role of pricing when a pharma company discovers a drug that is so valuable and innovative.

*In well-functioning competitive markets Industries don't have to defend their pricing choices to anyone in society (except its shareholders!). If a particular company prices it's product (i.e a new patent protected antibiotic for urinary tract infections) too high, consumers (patients) will substitute to cheaper alternatives. For the vast majority of common illnesses there are plenty of cheap and effective treatment doctors and their patients can choose from. Patent protection to encourage the investment in new technologies/drugs is helpful in justifying the investment but it does not create a monopoly nor eliminate competition. Thus, pharma companies must expend "more on marketing than on R&D ". In order to achieve an acceptable market penetration to justify investment you must market your products. If the condition is rare, and your product is truly innovative and value enhancing, then high prices are very justified and less can be spent on marketing until someone else can challenge your product with a cheaper but equally effective alternative.*

Several important concepts were touched by the above paragraph:

- a) Pricing of products and to whom it should please,
- b) Competition and substitution of products,
- c) Patent and protection of a new invention,
- d) Role of marketing for drugs on common diseases,
- e) Pricing high for revolutionary drugs for rare conditions.

People wish for something very useful and revolutionary, something that is not available yet and they wish were to be created by some magicians or angels. When that "something" was finally invented by humans and made available to the public but was unfortunately priced high, people would tend to demonize those inventors.

This is understandable somehow, part of "human nature" to wish to have something impossible be made possible for them. Like being made available to them for free or at a very low price. But inventions and discoveries, by nature, are scarce and limited. The scarcity (if not non-availability) of something -- like oxygen under the sea, or diamond or a super-fast car -- can be reflected by its price. The higher the price, the more scarce that product or service is. The lower the price, the more abundant a commodity is. Air is free and we pay nothing to breathe the air because its supply around us is unlimited.

Dr. Tej concluded his paper with the following observation:

*Anyway, in my humble opinion both Little red riding hood and the big bad wolf are getting screwed. "Society" loses out on an critical source of healthcare innovation and forces large deep-pocketed branded pharma firms into consolidating with generics manufacturers with everyone competing on price and nobody competing on quality. Worse yet, once the consolidation matures, the prices will rise anyway. So in the end, no specialty pharma companies; no pure generics manufacturers; only consolidated hybrids and a commoditized industry with limited incentive to compete on quality or price.*

It is important that people and their private enterprises would stick to certain division of labor. There are those who love high risks-high returns, long gestation and lots of hard R&D work; and there are those who love low risks-low (but assured) returns and little or no discovery and innovation work. Then people and their private enterprises can compete with each other in both product quality and product price.

The spirit of competition should be retained at all times at all places. When people feel there is too much competition on existing products, technologies and/or processes, then this will encourage, if not compel, them to do innovation work.

People are getting more demanding in healthcare. If they get sick, they want to get well within 1 or 2 days, not 1 or 2 weeks or longer. Hence, they demand more powerful, more revolutionary drugs and treatment. Health collectivism and coercion though would force pharma companies and retailers to focus on low price. If the price is deemed "expensive" even if the drugs are indeed highly effective and powerful, governments come in to impose price control and similar schemes. And this is where danger and uncertainties would flourish.

## **(16) Drug price control a year after**

[The Manila Times](#), August 19, 2010

The drug price control or price regulation policy will turn exactly 1-year-old on August 15, 2010. A year after its implementation began, has the policy achieved its goal of making essential, popular and branded drugs become more accessible to the poor? To help us answer this question, let us see some sales data from two drugstore chains, MedExpress/Manson drugstores and Watsons, which, starting this year, has become the second biggest drugstore chain in the country. The officials of these stores gave me permission to use their data for this article.

MedExpress' sales data for the price-controlled drugs showed the following: From August to December 2009 vs. same months in 2008, sales volume fell by 3.4 percent and sales value tumbled 34.3 percent.

From January to May 2010 vs. same months in 2009, sales volume has managed a 7.3-percent increase but the value plummeted by 65.4 percent, whacking the retailers' margins.

The sales value decline is now bigger than the mandatory 50-percent price reduction because there are additional government-imposed discounts, such as the mandatory 20-percent off for senior citizens and people with disabilities (PWDs).

Data from Watsons show that from mid-August to December 2009 compared to same months of 2008, sales volume of all price-controlled drugs increased by 35.9 percent although sales value declined by 13.2 percent. And from January to April 2010 vs. January to April 2009, sales volume has increased even higher to 57.2 percent while the peso revenue was flat at 0.2-percent growth.

What are the implications of these numbers?

At first glance, one may conclude that price control was a success in making more popular, previously expensive drugs by multinational pharma companies

become more affordable to the poor. Wrong.

Watsons drugstores are located mainly in the malls, especially in SM malls, which the richer ABC income class of people frequent. A 50-percent forced reduction in prices by some of the most popular, branded drugs by multinationals prompted the ABC class to patronize these products and abandoned some of the generics drugs that they used to patronize.

This result is a clear setback to the government's 22-years old campaign to promote generics through the Generics Law of 1988.

Did the government, the DOH officials in particular, foresee this huge and glaring contradiction between its old policy of generics promotion and its new branded drugs promotion?

What about the poorer consumers and patients, those who are in the rural areas and do not frequent the malls, did they also join the bandwagon shift to the branded drugs?

Judging from MedExpress' sales data, the answer seem to be No. The 7.3-percent modest growth in sales volume in the first five months of 2010 can be attributed to the shift by some of MedExpress' wealthier consumers in the provinces to the branded drugs. If the poor also joined the bandwagon, then the increase in sales volume would have been larger than 7.3 percent.

Prior to the imposition of price control policy last year, there was already a healthy competition among many pharma companies, especially between the innovators and generics manufacturers. One clear example is amlodipine molecule used to treat hypertension. The cheapest generic available on the market prior to price control was selling for only P8. The most popular brand name version was Pfizer's Norvasc, selling for P44 a 5mg tablet. After the mandatory 50-percent discount, it became P22.

For the poor who used to patronize the P8 generics, the P22 Norvasc was still expensive and thus, a shift to the branded drugs is still not viable.

Meanwhile, a number of small and independent drugstores, those which do not belong to any drugstore chains, have been forced to drastically shrink their operating costs including laying off some staff. Some also have had to stop selling some of the price-controlled drugs altogether as they encountered problems in getting rebates from the manufacturers, and they could no longer make useful profits. The situation of “cheap but not available” drugs in some rural areas has become more pronounced.

If the policy is a failure, then the DOH should consider advising the new President to recall or abrogate Executive Order 821 issued by the past President imposing price control on certain drugs.

It is time to move on, abandon politicized pricing of certain drugs, and focus our energy on the bigger issue of healthcare coverage for many Filipinos.