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Some Bark, Little Bite: The Draft National Pharmaceuticals Pricing Policy, 2011

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A new pharma pricing policy has been announced – the draft National Pharmaceuticals Pricing Policy (NPPP-2011). The new policy declares that all 348 essential drugs (as per the new National List of Essential Medicines, NLEM 2011) will be under price regulation. The shift to essentiality as criteria, from market share, is to be welcomed. However the policy still leaves a lot of loopholes for non-essential and irrational drugs to be made. It also has made calculating ceiling prices of the many drugs not in NLEM a tedious, if not impossible, exercise. In addition to the NLEM 2011, top selling 300 drugs of the IMS could have been covered.

The draft policy delinks the ceiling prices of formulations from the price of bulk drugs. Indeed, the arguments given in the draft policy for removing price control of bulk drugs do not make sense. Government should have kept the option of price control on bulk drugs in the event of cartelization or abnormal increases in price of bulk drugs. The latter may result in the scarcity of a particular essential drug formulation unless it is already overpriced relative to the cost of the bulk drug used. Worse, this may result in the bulk drug or the formulation not being made within the country. Secondly, using the WPI (Wholesale Price Index) to revise prices is not a good idea. It adds an inflationary element to the ceiling price automatically every year. The WPI (100 for base year 2004-05) for 2010-11 is 143.3. Most drug prices have not really increased 43 percent during the period. It would have made sense to have the ceiling price of a drug formulation tied directly to the related bulk drug price increase over the year.

Buttressing a Market Failure

The arguments for totally relying on Market Based Pricing (MBP) of formulations apparently does not recognize the fact that there exists a wide range of prices in the market of the same formulation and that prescribers, and therefore patients, tend to place more value on the costlier brands of the same formulation. In medicines unlike say soaps or cars, the brand leader is also the price leader: such phenomena are a result of anti-competitive forces, indeed they signify a market failure of sorts. The proposals of market based pricing do not attack these but in fact buttresses them by legitimizing higher prices.

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[1] *(A version of this article appeared in the* Hindu Business Line*, November 8, 2011. A more detailed critique of the policy has been filed in November 2011 in the Supreme Court in the ongoing pricing case of AIDAN, mfc, LOCOST and JSS vs Union of India.)*

The key para in the draft policy is para 4.7: "The Ceiling Price would be fixed on the basis of Weighted Average Price (WAP) of the top three brands by value (MAT value) of a single ingredient formulation drug from the NLEM on per standard dosage basis."

The WAP idea means that it will end up legitimizing high prices especially if the top three brands are overpriced: top selling brands – with a few exceptions - would be of the costliest brands. That is the norm of the medicines sector, thanks to asymmetry between consumer and prescriber/manufacturer. It means that that regardless of overpricing and profiteering, if the market "accepts" it, the price is ok. Never mind the patient may get poorer in the process. It also legitimizes the mistaken notion that higher priced drugs are of better quality. In our case, for example, albendazole (see Table below) selling above Rs 12-13 per tablet (price of current market leaders) would be legit.

A Comparison of Medicine Prices

(prices in Rupees)

Generic Name of Drug (1)	Unit (2)	Chittorgarh Tender Rate (3)	MRP Printed on pack/strip (4)	TNMSC Prices (5)	(Column 4/ Column 5) (6)
Albendazole Tab 400 mg	10 tablets	11.00	250.00	4.55	54.94
Alprazolam Tab IP 0.5 mg	10 tablets	1.40	14.00	0.51	27.45
Amlodipine Tab 2.5 mg	10 tablets	2.30	23.00	0.41	56.01
Atorvastatin Tab 10 mg	10 tablets	9.90	65.00	2.10	30.95
Cetrizine 10 mg	10 tablets	1.20	35.00	0.49	71.42
Diazepam Tab 5 mg	10 tablets	1.40	18.00	0.55	32.72

Note: TNMSC (Tamil Nadu Medical Services Corporation) prices are from its website, http://www.tnmsc.com/tnmsc/notification/Drugs232.pdf, for 2011-12. Chittorgarh prices are of well-known companies and are at http://chittorgarh.nic.in/Generic_new/generic.htm. Column (6) gives an idea of how many times the retail market MRP is in comparison to the TNMSC procurement price – the latter being almost near the cost of production.

Ceiling prices need to have a clear relationship with the cost of the raw material at least. The WAP formula has in effect no relation with the cost of raw material, let alone the cost of other inputs. Column 6 in the above table shows that the MRP to raw material ratio is about 3000 % to 5000 % in

quite a few essential drugs. Should a Government legitimise such super profits? Most retail pharmacies do not keep cheaper versions because of lesser margins; eventually all lower priced brands will move towards the higher ceiling price even as 'premium' prices, including that of overpriced imported drugs like Novartis' Glivec, will take a hit with the WAP formula.

The draft policy gives a formula to discourage non-standard dosages. The same thinking could have been applied to discourage irrational and unscientific drugs outside the NLEM. One can discourage irrational combinations, and attempts to circumvent the ceiling price, by taking the cue from the Pronab Sen Task force Report – from which many of the recommendations have been taken anyway – which says, "For formulations containing a combination of a drug in the NLEM and any other drug, the ceiling price applicable to the essential drug would be made applicable." Sales tax and excise duty could be higher for drugs outside NLEM 2011 and zero for NLEM drugs. The draft policy could also take another recommendation from the Pronab Sen Committee: debrand, that is remove brand names, to ensure true competition among generics.

Inexplicable Exemptions

The draft policy lists certain exemptions which again are inexplicable: all drugs costing less than Rs 3 per unit are to be exempt. This again legitimizes overpricing of drugs which cost around 10-20 paise and begs them to be priced near Rs 3/-. An example is cetrizine which costs less than 15 paise per tablet to make but the brand leaders are available near Rs 3/-. Why should this be condoned? Should much needed iron plus folic acid tablets which cost to produce less than 10 paise per tablet be given leeway to sell at or near Rs 3/-? Most retailers will give only a strip of 10 even when I need a couple of tablets only.

We also do not see the reason why drugs which are part of Hospital Supply as maintained by M/o Health and Family Welfare; and drugs which are part of Public Health Products as maintained by M/o Health and Family Welfare should be exempted. If by the latter government means vaccines, we do not see the reason for exemption as vaccine PSUs could be revived and their prices should be the ceiling price. Otherwise, it will encourage the corruption which is at present rampant in drug procurement and/or justify inefficient public procurement at high prices.

So what is a better pricing policy? That will be one that brings down the prices of overpriced drugs, that has some linkage to the actual cost of production, and therefore to the cost of the raw material, and does not legitimize overpricing of drugs. Nominally reducing the price of the top-selling brand is tokenism. A good starting point would be to take as reference price the prices of well-run public procurement systems and take a multiple, say 4 to 6, of the reference price as the ceiling price. The present WAP procedure will make the ceiling price 20 to 70 times the public procurement price – which is a bit rich.

The draft policy It gives the impression of a policy cobbled to satisfy perfunctorily the Supreme Court Orders of March 2003 and October 2011, one that will leave major players mostly unaffected. A policy with some bark and a little bite.