Pharma Policy 2012 and Its Discontents

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The Government of India, after several hiccups, notified the new National Pharmaceuticals Pricing Policy (NPPP) 2012 during the first week of December 2012.1 This was following the orders of the Supreme Court – in a public interest litigation (PIL) that the All-India Drug Action Network (AIDAN) and others filed in 2003 – that the government bring all essential medicines under price control. However, the new method for determining the price ceiling, called a market-based pricing (MBP) mechanism, is different, and as we will show, problematic. In addition, there are several other problems with the newly notified policy.

Since 1979, the method for calculating ceiling prices for drug price regulation has been cost-based pricing (CBP). That is, the cost of raw materials plus costs of conversion, plus the maximum allowable post-manufacturing expenses (MAPE) of 100%, which includes the profit of the manufacturer and various distribution costs. In 1979, the MAPE was 40% for essential medicines, but was later raised to 100%.

Market-Based Pricing Policy

According to MBP, the ceiling price of a medicine in NLEM 2011 would be the simple average price of all its brands that have more than 1% market share. This formula was proffered despite a direction from the Supreme Court to follow the older cost-based methodology. The additional solicitor general certified in a written opinion to the department of pharmaceuticals (1009) that the Supreme Court’s suggestion was not binding as policymaking was the prerogative of the executive.

The Supreme Court has said time and again that it does not get into policymaking. However, the issue the petitioners raised was that exorbitant prices deprive the poor of essential medicines and thereby violate the right to life. The Court’s remarks during the hearings show that the bench’s concern was that essential medicines should be affordable to the common people. Now, it is an open question whether the Supreme Court will continue to stick to this as the central point in this case, or will stay within the Laxmanrekha (line) of judicial limitations as interpreted by the government. Here, we limit ourselves to discussing the merits of the new national pharma pricing policy.

First, the government has provided no rationale as to why CBP is to be abandoned when the retail price for telephone charges, electricity, autorickshaw and taxi fares, and so on are all decided on cost. MBP is never used for any price regulatory purpose. One fails to understand the reason for the sudden radical departure from the well-established method of cost-based pricing for regulatory purposes.

Second, the simple average formula is as faulty as the other market-based mechanisms that have been tossed around in recent months (like weighted average price of brands with more than 1% market). It is faulty for the following reasons, among others: (i) the ceiling price arrived at by MBP continues to have no relation to the cost of production, (ii) due to a unique information asymmetry and the vulnerability of the patient, the prices of brands reflect brand value rather than actual cost of production. This leads to unreasonable super-profits being earned by pharma companies (to the tune of 200% to 4,000%) and the resultant ceiling price arrived at will continue to be high, (iii) the prices of brands are high, among other reasons, because of questionable marketing practices that involve brand promotion by pharma companies (including sending members of the medical profession on paid holidays), which encourages not only inefficiency and market distortions, but also unethical

**References**

1. The Court’s suggestion was not binding as policymaking was the prerogative of the executive.

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behaviour,2 and (iv) any price ceiling that has no relationship to the cost of production is absurd and indicates market failure. To arrive at a price ceiling on the basis of a flawed market mechanism is illogical.

Market failure is anyway the chief characteristic of health and medicine markets where competition works, if at all, only in the early days of a new drug brand. It eventually settles down to the peculiar Indian phenomenon where brands of the same medicine sell at vastly different prices – many a time the highest priced brand is 30 to 40 times more costly than the lowest priced. This differential climbs to even 50 to 60 times if one compares the retail prices of market leaders with the same medicine.

Table 1 shows that simple average market-based pricing is a bit of casuistry in that it apparently brings down some prices, but ends up legitimising high margins. For atorvastatin 10 mg, used in lowering high blood cholesterol, the market leader’s price is Rs 110 for 10 tablets, whereas the price as per CP under the norms of the Drug Price Control Order (DPCO) 1995 with 100% margin is Rs 5.60. The simple average price (of brands with more than 1% market share) is around Rs 50, and the Tamil Nadu government’s public procurement price is Rs 2.10 for 10 tablets. In the case of amlopidine 5 mg (not in the table) – used to treat high blood pressure – the simple average ceiling price of Rs 25.70 is greater than the market leader price of Rs 15.60, whereas the CP ceiling would be Rs 1.77 for 10 tablets. Profit margins are nearly 1,000% in both cases.

Indeed, the government has missed a valuable opportunity to address the question of what the legitimate profit margin is for a medicine formulation – 100% or 1,000% or 4,000%? Also, it has not addressed how much good quality and good manufacturing practice (GMP) standards cost, and the associated issue of how a range of companies, all approved by the government’s own department and also exporting to well-regulated economies like the US and European Union (EU), are able to produce drugs at such vastly different, and often very competitive, prices. Therefore, high prices cannot be because of high quality standards per se. Nor can they be because of R&D, on which the top 30 Indian companies spent an average of 7% of their net sales in 2011-12.3

Problems with Reliability of Data
Paragraph 4 (ix) of the policy document says,

The CP (ceiling price) for a drug listed in the NLPM would be the Simple Average of Prices as calculated on the basis of IMS data six months prior to the date of announcement of the new National Pharmaceutical Pricing Policy, i.e., the ‘Appointed Date’ for bringing the new Policy into effect. For a drug whose data is not available in IMS, the NPPA (National Pharmaceutical Pricing Authority) will commission the data within a reasonable time for determining the Simple Average Prices also on the basis of prices prevailing six months prior to the Appointed Date. Thus the Simple Average Prices data for the drugs available in IMS data and collected by NPPA would be same.

Once the Simple Average Price is fixed, NPPA would monitor its implementation on a continuous basis through a proper methodology and system (italics added).

What does this mean? First, the data on market share by brand, volume and price is not generated by the government or a neutral public agency. On the contrary, the generator of the data, IMS Health, is a private company that is an Indian subsidiary of a multinational company of the same name (http://www.imshhealth.com). Earlier, the Bureau of Industrial Costs and Pricing (BICP) fixed prices in various sectors, including medicines. The data sets of IMS Health are from a provider of information related to the pharma industry, and are methodologically neither robust nor reliable, and limited in its coverage. The IMS Health data sets are prohibitively expensive, running into almost Rs 24

Table 1: How Gross Overpricing Will Continue Despite Simple Average Market-Based Pricing Mechanism

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<td>2</td>
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<td>20.19</td>
<td>5.60</td>
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<td></td>
<td>Lowers blood cholesterol</td>
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<td>Atenolol 50 mg (14 tabs)</td>
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<td>11.66</td>
<td>3.50</td>
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<td>Domperidone 10 mg, Anti-vomiting agent</td>
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The simple averages are underestimates as they are based on 2008 IMS figures.
lakh a year, and are not accessible in the public domain. The public would find it very difficult to verify the data on which a public policy is based. The question that needs to be asked is whether a public policy can be made by data that is neither accessible nor subject to independent scrutiny by experts and civil society groups, as well as research and public policy institutes working on medicines and health. Using private data like that of IMS Health for a public policy affecting millions does appear untenable. An alternative pharmaceutical market research company has been around for some years, set up by All Indian Origin Chemists and Distributors (AIOD), and is called AIOD Pharmasofttech AWACS. Industry insiders increasingly seem to prefer the latter as it gives more real-time information on the pharma retail market. And, suspicion over IMS Health figures have intensified with AIOD AWACS giving a growth rate much higher than them.4

The World Health Organisation (WHO) has questioned the validity of IMS Health data for decision-making on prices of medicines. Other criticisms of the data and methodology of ORG MARG (the predecessor of IMS Health) have been made by the Government of India’s Drug Price Control Regulation Committee (DPCRC), 1999.5 These in themselves are good arguments to reject the formulation of a vital public policy, specifically a drug pricing policy affecting a billion and millions does appear untenable. An alternative pharmaceutical market research company has been around for some years, set up by All Indian Origin Chemists and Distributors (AIOD), and is called AIOD Pharmasofttech AWACS. Industry insiders increasingly seem to prefer the latter as it gives more real-time information on the pharma retail market. And, suspicion over IMS Health figures have intensified with AIOD AWACS giving a growth rate much higher than them.4

The list of 348 drugs in the NLEM 2011—to be brought under price regulation in the pharma pricing policy—are mostly single ingredient formulations. The NLEM drugs cover only Rs 16,000 crore of the total domestic market of Rs 68,000 crore.7 Therefore, the great mass of medicines in the Indian market is outside the NLEM. And, most of them are fixed dose combinations (FDCs).

To illustrate the gravity of the situation, the sales of the antibiotic cefixime as a single ingredient formulation are Rs 788.40 crore, while sales of combinations of cefixime are Rs 644.10 crore (Pharmatrac Top 1000 SKUs, October 2012). That is, both are about the same in value terms. The situation with other antibiotics and other useful NLEM drugs is similar. They are consumed as much in combinations, and irrational ones at that. Estimates of the number of FDCs vary between 40% and 60% of the number of formulations in the Indian domestic market; the latter figure is estimated to be around 1,00,000.

If it were really concerned, the NPPA would lose sleep on how it proposes to control the existing FDCs. The policy has nothing to offer on the FDCs in the market. Though there are a few rational FDCs that are needed (such as calcium with vitamin D, or iron with folic acid), the majority of the FDCs in the Indian market are irrational (like combinations of anti-diarrhoeals with vitamins). As a policy measure, all irrational FDCs need to be weeded out of the market as they only make patients waste money. If the total domestic Indian market is estimated at Rs 68,000 crore, at least one-third of this is wasteful and unnecessary.8

If the policy is silent on the existing FDCs in the Indian market, its response to new proposed FDCs is only marginally better. Paragraph 4 (xviii) of the policy document says,

The production levels, availability and accessibility to the non-NLEM drugs and formulations should not fall after price control is introduced and the Department of Pharmaceutical will ensure that production levels are maintained by an appropriate mechanism. If a manufacturer of a non-NLEM drug with dosages and strengths as specific in NLEM, launches a new drug by combining the NLEM drug with another non-NLEM drug or a non-NLEM drug by changing the strength and dosages of the same non-NLEM drug, such manufacturers shall be required to seek price approval from the Government before launching the new drug.

We do not know how the government—under what law—proposes to arrest the first, that is, ensure the “production levels, availability and accessibility to the non-NLEM drugs and formulations” do not fall after price control. Nor is it clear how price approval will be granted for new combinations of two or more NLEM drugs or a NLEM plus non-NLEM drug. Will the government go by cost plus or on the manufacturer’s say-so, especially for the latter? If the non-NLEM addition is irrational or unjustified, it ought not to pass the committee for approval of new drugs under the Central Drugs Standard Control Organisation (CDSCO).9 If it does pass, the simple average formula will not obviously be applicable as there will be no other brands of the same combination to take an average. Cost plus would be an option for the non-NLEM addition. As for formulations with a change in dosage, the pro rata formula mentioned in the draft NPPP 2011 could be adopted with a factor to discourage non-standard dosages. For new combinations of two or more NLEM drugs—assuming they pass the drug approval committee—one could simply adopt pro rata combinations of their individual ceiling prices as the ceiling.

Expand Essential Drugs’ List

The NLEM 2011 consists of 348 drugs. The term “essential” and NLEM are not the same. The total number of molecules being used in India exceeds 800. Thus even the expanded list of 348 drugs leaves out many essential medicines from price control. For example, in the case of medicines needed for treatment of bronchial asthma, only salbutamol is included in the current NLEM. Other essential medicines such as theophylline, doxofylline, montelukast, and zafirlukast are missing from this list. Many of these are useful in life-saving, tertiary-care situations. It is quite possible, therefore, that critical care medicines will continue to remain costly. Also, it can be seen that the various essential drug lists of states are different, and according to local needs. The logical step would be for the government to set up a committee of experts to review and expand the current list of essential medicines on a scientific basis. Otherwise, there is every good chance that the NLEM 2012 will not be adhered to by the state governments.
price of the combination. The policy document does not, however, throw light on these aspects, and if left to the discretion of the NPPA, they run the risk of being deemed arbitrary, or worse, being susceptible to pharma industry lobbying.

Migration

The other real possibility is migration to other drugs of the same therapeutic/chemical class that is not in the NLEM 2011, the “me too’s.” The policy is blissfully silent on this. Let us, for example, consider two chronic conditions – hypertension and asthma. Among anti-hypertensives, while enalapril will have a price cap because it is part of the NLEM 2011, the prices of all other widely used ACE (angiotensin-converting enzyme) inhibitors such as captopril, fosinopril, imidapril, lisinopril, perindopril, quinapril, ramipril, andtrandolapril will be free from any regulation because they are not in the NLEM 2011. In the case of Angiotension II Receptor Blockers (ARBs), used in the treatment of high blood pressure, other than losartan, the prices of all such as candesartan, irbesartan, telmisartan, valsartan, and olmesartan will not be regulated, again because they are not in the NLEM 2011. Among drugs used in asthma, except for salbutamol and the hardly used ipratropium, all other agents in high use such as the long-acting beta2-adrenoceptor agonists (LABA) salmeterol, formoterol, and bambuterol will have no ceiling prices because they are not in the NLEM 2011. The remedy is to put all drugs of the same therapeutic class under the price ceiling, either by modifying the policy or by modifying the NLEM. And, all drugs of the same chemical-therapeutic class will need to have the same price ceiling – thus, all “prils”, all statins, all ARBs, and all LABAs will need to have the same price ceiling, unless specially justified. Or else, migration to drugs of the same therapeutic and chemical class will take place.

Irrespective of input costs, drug manufacturers will be free to hike the prices of all medicines at the same rate as the increase in the wholesale price index (WPI) for manufactured goods year after year. The WPI is never negative. The automatic increase of retail price is not called for – at best one can increase conversion and packing costs with the WPI. Conversion costs are a relatively small part of the total price. The active pharmaceutical ingredient (API) or bulk drug (or raw material) component of a tablet or capsule is the bulk of the cost of the formulation and does not significantly increase year to year, and in many cases is known to come down. But when it does increase, it increases significantly. The examples of norfloxacin, doxycycline, and sulphamethoxazole come to mind among the recent list of 74 controlled drugs (under DPCO 1995). This resulted in considerable difficulty for formulators and patients, a situation that could have been avoided by prompt revision of the ceiling prices of the bulk drugs. One also wonders under what formula the ceiling prices of the subset of 74 drugs that will now be part of the NLEM – once the one-year moratorium is over – will be decided. One can see them going out of the market if manufacturers decide that the old controlled price is not good enough for them. These are only some of the problems a cap mechanism would have avoided. Poor implementation of an MBP system, such as it is, will be a recipe for industry-wide disaster. Cassandras will say “I told you so” and the status quo of free pricing for most of the market (as at present) will be restored.

The proposed new policy is non-committal on the exorbitantly priced patented medicines of multinational corporations (MNCs), except for saying a committee has been formed, one that has not moved forward in years. Surely one of the cornerstone of such a policy for patented drugs ought to be the automatic issue of compulsory licence (CL), which can promote competition on these costly molecules and bring prices down. For example, the prices of sorafenib, used in certain cancers, have declined substantially after issuing CLs. There are also problems with the proposal to tie the price ceiling of the patented drugs with the gross national product (GNP) of the country.

Outcome and Alternatives

What of the impact on the pharma industry? Industry estimates are that the NLEM covers around Rs 16,000 crore of the Rs 68,000 crore domestic market, which means only about 25% of it. According to a report in the Times of India, “The new pricing mechanism will lead to a price erosion of over Rs 1,400 crore, according to research consultancy IMS, while AIOCD estimated the impact to be around Rs 1,800 crore” (23 November 2012). We find these are on the high side, but even at these higher estimates, if one factors in that the pharma industry is growing at a compound annual growth rate of 15% and more, this will translate into an almost negligible impact.

For consumers and patients, this will mean that the reduction in prices overall would be negated in a maximum of two years by inflation and an increase in ceiling prices in accordance with the WPI. More relevantly, the government and industry will try to garner brownie points for regulating prices without actually having done so – recollect that at least 75% of the market is untouched. The policy will have no impact on other members of the same therapeutic class or on existing FDCs, rational and irrational. Worse, it will reduce the prices of certain top brands, but not close potential escape routes for good. And, it will leave a lot of useful life-saving drugs used in tertiary care outside the price control basket (along with the above-mentioned drugs of the same therapeutic class and therapeutic equivalents).

What we need is an Ockham’s razor in pharma policymaking – the issue of price regulation of medicines in India cannot be addressed without addressing the proliferation of combinations that dominate the market and contribute to therapeutic and regulatory chaos. These need to be examined for rationality, and the unscientific and irrational ones need to be weeded out. In all, only formulations of about 800 molecules, mostly single ingredient unless otherwise justified, would need to be in the Indian market. And brands have to be removed from medicines (that is, debranded), a move suggested by the Pronab Sen task force as well as bodies like the wHo. If necessary, the name of the company can be prefixed to the generic name of the drug (like GSK Paracetamol, instead of Calpol), a practice successfully followed in Bangladesh since 1982. In no country with a well-developed regulatory agency are
medicines out of patent sold predominately under brand names.

The price ceiling itself would need to be simpler and more efficient. We suggest that the prices of APIs that go into a formulation can be "discovered" by the excise duty returns (for instance, the exc-3 forms) filed online monthly by manufacturers, and by actors at every stage up to the formulation manufacturer. All it needs is suitable software that picks up the prices of the APIs/bulk drugs in the excise returns and feeds it to the NPPA. And, the ceiling price can be cost plus, and online, without manufacturers physically making trips to the NPPA for lobbying or otherwise. The ceiling price, alternatively, can be a simple multiple of the cost of the API component in the formulation. Bangladesh has had this system for its list of essential drugs since 1982.

The only rational, scientific ceiling price is one that has a clear-cut relation to the cost of raw material and cost of production. All else is mere causistry and statistical sophistry.

NOTES
2 Even as we write this, there is news of Pfizer having lobbied on “issues related to a Supreme Court decision on generic medicine pricing” and certain patent cancellations matters. See “3 US Entities Lobbied on Tax Plan”, Times of India, 17 September 2012.
3 http://pharmabiz.com/table/7214Table.aspx, 12 November 2012; accessed on 17 December 2012. The actual figures ranged from 1.5% to 20.3%. Expenses for Abbreviated New Drug Application (ANDA) filings have been included under R&D.
4 See “Pharma Market Researchers Clash Over Numbers”, Financial Express, New Delhi, 12 August 2012. “In June, IMS had declared a growth of 7% of the industry while AIOCD went with an estimate of 16%; for July, AIOCD said the market continued to grow at 15.6% while IMS reported a slowdown, pegging the growth at 3.4%; for the April-June quarter, IMS’s growth estimates stood at just over 10% against AIOCD’s figures of over 17%.”
5 In a piece titled “WHO Warns India Over Drug Pricing Data”, 17 January 2012, Pharma Times, reported (see also “Healthcare Workers Stress Need for Independent Data on Medicine Prices”, Economic & Political Weekly, 15 January 2012, Mumbai): “the World Health Organisation (WHO) has told the government that ‘a major problem exists’ with its method of obtaining drug pricing data. India uses data from IMS Health, which collects medicine volume and prices at one point in the supply chain, usually at the wholesaler level, i.e., WHO, in its response to the government’s draft National Pharmaceutical Pricing Policy (NPPP). While the volume data from IMS is reliable, its pricing data ‘does not take account of discounts, rebates and bundling deals,’ says the Organisation, adding that ‘when the data is collected at the level of the wholesaler [it estimates] the retailer and patient prices’...”

Moreover, the agency (WHO) is critical of the fact that the NPPP (that is the then proposed policy when this comment was made) contains no commitment to releasing information in the public domain, which it says would make it impossible for companies and other organisations to check whether the officially-set ceiling price is in fact correct. WHO also takes issue with the government’s plan to base the ceiling price for products within individually therapeutic groups on the group’s biggest seller, pointing out that drugs with the biggest volume sales are often the highest-priced, so such a policy would increase prices and establish incentives to raise prices progressively.

“It also suggests that India needs a policy for negotiation at the time they receive their marketing authorisation and that this should include pharmacoeconomic evaluation” (that is evaluation based not only on costs but on efficacy, risks and benefits to the patient).

Earlier, the ORG-MARG (which was subsequently merged into IMS Health) methodology has been also faulted for its inaccuracies and for not reflecting the field level realities of the country. We quote below from the DPCRC (Drug Price Control Review Committee, 1999) Report, Chapter 5: “The ORG-MARG study on “Trends in price index of pharmaceutical formulations (1995-1998)” conducted in March, 1999 brings out that the pharma market during the said period increased by 5.3% and the index increased by 10.5%. It implies that there was a decline in the quantity produced during this period which is not factually correct. While working out the index numbers for each year, the base year figures have been substantially changed by ORG-MARG for which no satisfactory reasoning is given. Clearly, a statistical bias appears to have been introduced to keep the index depressed. For instance (i) In Table 3.11 the value in 1994 is worked out by taking the quantity of 1995 and prices of 1994, resulting in a lower value. And to work out the change in the price index, the value in each of the base years has been jacked up. Same is true of other tables/exercises given in the Report. Ap-propriately, a common base figure (1994) should have been taken to arrive at a realistic assessment of the real increase in prices in 1998.

Moreover, the prices given in the ORG report are the prices at which drugs are sold to the wholesale chemist. The retail prices for the consumer are those which are printed on the pack and which normally are changed by the chemist after adding the local taxes, etc. Therefore, the tendency of many of the manufacturers to retain the price for the wholesaler static while increasing the consumer price will not reflect the real increase through the ORG study. In view of these weaknesses, the committee does (not) consider their assessment as reliable.”

Likewise we have comments of the Ministry of Health (as in its comments to the Drug Price Control Review Committee – DPCRC – formed by the Government of India, November 1999) on the methodology of ORG (applicable to its successor IMS 100). “The Ministry of Health strongly feels that ORG MARG data neither gives the real picture of the market nor is available for more than a third of the total volume of the market. The essential drug list as many of such drugs are primarily used directly in hospital-based healthcare. Cheap drugs need to be available not only at the retail level but in the hospital care system too. There-fore, it is essential to have a database, especially in respect of all the essential drugs, to get the complete picture of their production and sale in the country. Only then would it be possible to take a more rational decision on price control.

Ministry of Health supports the proposal to collect the information from the Department of Revenue in order to get the real market data about the production and sale of these drugs. This may be collected in the form of a list of drugs under price control be revis ed at that time. Meanwhile, the immediate exercise which will be carried out may be done on the basis of data of ORG MARG as of March 2001 rather than that of 1999”.

6 We might add that tertiary care situations can often occur, and do, at the primary care level.

7 As per PharmaTrac October 2012 (a product of AIOCD Awacs), the number of NLEM drugs is only 18% in the top selling 300 formulations and their value is Rs 2,355 crore out of the total of Rs 14,450 crore (for the top 300). That is, the NLEM share by value in the top 300 is only 16.3%. Extrapolating for Rs 68,000 crore, that is the entire universe of domestic formulations, the NLEM share will be Rs 11,000 crore. We therefore think the industry estimate of the share of Rs 16,000 crore, though on the higher side, is acceptable for arguments in this paper. If one goes serially down the list of products with decreasing sales, those outside the NLEM are APIs drugs and rational products become less frequent. A small caveat, however. The figure of Rs 68,000 crore includes at least 10%-15% for APIs. So our figure next year one may deflate by a suitable factor to arrive at a more accurate figure for domestic formulations.

“The proposed policy will cover 30% of the industry and will bring down the average prices by about 10%.” (“New Drug Pricing Policy May Impact MNCs Most”, Business Standard, 30 September 2012). According to research firm Prabhudas Lilladher, the revenues of Cipla, Dr Reddy’s Lab, Ranbaxy, and GSK Pharma from domestic formulation are likely to be effected by 5%-10%. (www.moneycontrol.com, 28 November 2012).

8 An unpublished study (2012) by Ravi D’Souza for LOCOST, using IMS data, showed that in the top selling 300 medicines with a moving annual total (MAT) value of Rs 16,000 crore, about one-third (that is, 100) are irrational both by number and value. Only 46% (or 136) of the 300 drugs are in the NLEM in 2011, constituting roughly 40% in value terms. For a similar analysis using PharmaTrac October 2012 data, see Note 7.

9 Any FDC, if it is to be manufactured and marketed for the first time in India, will be consid ered a new drug as per Rule 122 E of the Drugs and Cosmetics Rules, 1945.

10 See Note 7.

11 The “new pricing mechanism will lead to a price erosion of over Rs 1,400 crore, according to research consultancy IMS, while AIOCD estimated the impact to be around Rs 1,800 crore. Though the tweaked pricing formula would lead to an additional impact on companies, but when calculated on an industry size of over Rs 67,000 crore, it is marginal, around 2-3%, or over Rs 1,500 crore. The scope of the policy is around 17% of the total pharmaceutical market, while coupling it with the existing medicines under price control, the coverage increases to around 30%.” (“Booster Shot: Cabinet Okays Pricing Policy”, Times of India, Mumbai, 23 November 2012; accessed on 18 December 2012).

12 See notes 7 and 8.

13 See the Ministry of Commerce and Industry website on WPI at http://www.eaindustry.nic.in/wpi_data/display/display_data.asp. The WPI for all commodities (base 2004-05 = 100) for 2010-11 was 143.2 and for 2011-12 was 156.1. For chemicals and chemical products, the WPI growth year on year is slightly less. The consumer price index gallops at a higher rate than the WPI. Accessed on 18 December 2012.

14 Incidentally, Bangladesh has better health indicators than India.