Pricing Policy a well thought out plan for the benefit of the public

As a responsible national newspaper we are perturbed by the degree of misreporting and misinterpretation of facts in your Editorial of 06 November 2016 pertaining to the price restrictions placed on some commonly used drugs by the National Medicines Regulatory Authority (NMRA) of the Ministry of Health, Nutrition and Indigenous Medicine.

Your column alleges that the list of drugs selected for price control is not 'comprehensive' and an exercise based on a 'simplistic arithmetical formula'. Please note, the forty eight drugs were carefully selected based on the principle of essentiality which forms the basis of SenakaBibile principles on pharmaceuticals using the 2013/14 Essential Medicines List of the Ministry of Health. In addition a number of other important issues were taken into consideration including drugs used for a wide range of common medical conditions affecting the general public such as diabetes, high blood pressure, heart disease, various infections, asthma, epilepsy, psychiatric disorders and muscular-skeletal disorders. India started a similar process in 2013 for about 40 drugs that has now been expanded to cover almost 500 medicine under a Maximum Retail Price fixation model.

We feel that your fears of some multinational companies withdrawing from the market due to the price interventionism unfounded. One of the biggest multinational operating in the country, GSK (Glaxo), the manufacturer of a wide range of pharmaceuticals including a brand of paracetamol (Panadol) has agreed to bring down the price of this product from the current Rs. 3.00 to Rs. 1.30 per tablet with immediate effect. Further, they have assured uninterrupted supplies of their brands of medicines in the market, and have decided to place an advertisement in the newspapers announcing these decisions. We have to date received similar assurances from many importers of pharmaceutical products.

Regarding your concern of "Innovator" drugs pulling out of the Sri Lankan market due to the imposed price fixation, it should be noted that such drugs have been protected by patent rights for a long period of time allowing them to recover the cost of R&D that has gone into developing such products. None of the products brought under this pricing regulation are currently under patent protection, and hence do not need additional cost benefit over and above the stipulated ceiling prices. Please also note, no country depends solely on "innovator" products of medicines. Generic medicines play a major role even in the USA where 40 percent of generic and over-the counter drugs are manufactured in India, making India the second-biggest supplier of generic medicines to USA. The 2015 WHO Guideline on Pharmaceutical Pricing Policies promote the use of generic medicines as an effective method of managing drug prices. The Ministry regulation on pharmaceutical pricing does that by making quality generics more affordable to the public.

Regarding allowing ‘market forces’ to play their role instead of implementing price controls, we wish to point out that this is not possible due to leverage exerted through brand-name prescriptions andpreferred brands being ‘pushed’ at pharmacists, influencing the freedom of customer choice or decision making. In fact a recent report on pharmaceutical pricing in Sri Lanka compiled by aWHO expert clearly states 'market forces' are distorted in the country’s pharmaceutical market and cannot be relied upon to bring in a reasonable pricing structure even though the government has exempted medicines from taxes/ other duties, preventing the benefits of such concessions reaching the patients.In addition pricing policies adopted by certain pharmaceutical companies do not allow genuine market force driven completion to determine prices of medicines.

The Sunday Times editorial goes on to claim thatthe present MRP based price fixation will create illegal parallel imports to the country.lt should be noted that even today this is happening due tomassive price differences between India and Sri Lanka. For example an ‘innovator brand’ of Rosuvastatin 10 mg is SLRs 28.00 in India and SLRs 150.00 in Sri Lanka. This massive difference in price for the same branded product has resulted in ‘suitcase imports’ from India. When local prices are reduced this practice is likely tobecome unattractive to unscrupulous elements. To safeguard the quality and safety of drugs marketed locally, the NMRA and Ministry of Healthare determined to end such illegal practices in the future.

The reported jettisoning of the CIF + 85% formula was done for very good reasons as CIF pricesareknown to be manipulated by importers through various mechanisms such as over invoicing, rebates and discounts in the supply chain. The WHO expert report identifies this as a major problem and strongly recommends a CIF plus pricing model should not be implemented. The NMRA has been pressing for a “verifiable” CIF from pharmaceutical importers for a long time.The pharmaceutical chamber, which was silent on this issue all this while has at last indicated their willingness to look into this unethical practiceresorted to by its members and work with the NMRA in the future.

The statement that private sector has not been consulted before implementation of price control and has taken suppliers by surprise is incorrect.The pricing formula was presented and discussed with the Chamber of Pharmaceutical Industry (SLCPI) initiallyin September 2016, and subsequently on numerous occasionswith NMRA officials.The Honourable. Minister of Health discussed the proposed pricing model in great detailwith SLCPI officials (including its President, Vice President & Secretary) on two occasions.Further, the Honourable Minister has been on record on the special gazette notification on pharmaceutical pricing months in advance, both through public announcements and statements in the Parliament.