

Access to medicines in the Philippines: Overcoming the barriers

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Jt has been almost a decade since the enactment of the Cheaper Medicines Act, which aims to promote and ensure access to affordable quality medicines for all. The said passage has led to the decline of medicine prices since 2009, primarily through the efforts of the Department of Health (DOH) to implement the law using measures on maximum drug retail prices (MDRP) and the government mediated access prices (GMAP).¹ Even the prices of generic medicines which the said measures do not cover have also fallen. It appears the measures taken have been successful.

Not quite. In fact, access to quality health care without incurring financial hardship continues to be an aspiration for many Filipinos (NEDA 2016) given the high out-of-pocket (OOP) spending on health care in the

Philippines. This is despite the fact that the Universal Health Care (UHC), the Philippine government's social contract with Filipinos, requires the balancing of the three dimensions of health-care program, which are what services it covers, whom does it include, and how to pay for it.

Based on the 2012 Family Income and Expenditure Survey (FIES) of the Philippine

¹ Executive Order No. 821, titled Prescribing the maximum drug retail prices for select drugs and medicines that address diseases that account for the leading causes of morbidity and mortality, enabled the MDRP which directs manufacturers to cut by half covered medicines. Meanwhile, GMAP, issued by DOH Advisory Council Resolution 2009-01, titled Implementing the voluntary price reduction for at least 16 molecules (or 41 drug preparations), negotiates price reductions between the DOH and the pharmaceutical manufacturers. Both were issued in 2009.

² This figure was 47 percent in the 2015 FIES.

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Statistics Authority, OOP spending on medicines accounted for 50 percent² of the total health-care spending in the country (Ulep and Dela Cruz 2016). This makes the weak access of the population to medicines a key problem in achieving UHC. A chronic and debilitating illness hitting a middle or lower income family can be its ticket to join the ranks of the poor or remain poor, particularly if the main income earner becomes the affected member.

This *Policy Note* explores the barriers in access to medicines of Filipinos. It also presents key recommendations and strategies policymakers should consider in advancing UHC in the country.

Dimensions of medicines access

Access to medicines in the framework of the World Health Organization (WHO) is circumscribed by the trilogy of medicine prices, affordability, and availability (Cameron et al. 2014). Generally speaking, high prices of medicines tend to weaken access to medicines by making them less affordable and available. However, lowering the cost does not automatically solve the problem. The result depends on the poverty situation and the nature of the health-care system of a country.

If the health care is predominantly private, reducing medicine prices only increases access in a country with adequate purchasing capacity. The affordability of medicines actually has two aspects, which include the level of medicine prices and the income of

the patient. While a lower medicine price increases real incomes, such increase does not guarantee adequate purchasing capacity. In fact, medicines can remain unaffordable despite lower prices if the private health-care system has already excluded the poor.

Meanwhile, a predominantly public health-care system paid with general tax money or through health insurance may likely be able to convert reduced prices into actual medicine purchases, regardless of the poverty situation or the purchasing power of the population. Its downside, however, is its cost. A society with a significant poverty problem, for instance, requires more public resources, thereby crowding out other social and developmental spending. Nonetheless, reduced medicines prices alleviate this burden.

In general, medicines are available in a country with adequate purchasing capacity. But given that medicine transactions can be scarce in a largely private health-care system of a country with a significant poverty problem, the area that is underserved or not served at all by the private sector medicines distribution network can be wide.

Measures to improve access

The Philippine government currently implements measures to improve medicine access, such as promotion of generic drugs, enactment of the Cheaper Medicines Act, public sector importation of cheaper medicines, centralization of the procurement of medicines for public hospitals and clinics,

and establishment of village pharmacies (*Botika sa Barangay*), among others.

Since 2009, the DOH has price capped medicines under the MDRP and the GMAP programs (Table 1). Executive Order No. 821 ordered a 50-percent reduction of prices of MDRP medicines, while private manufacturers voluntarily offered to halve the cost of GMAP medicines.

Reduced medicines prices

Several studies on the country's medicine situation found that medicines are relatively expensive in the Philippines (Batangan 2005; HAIN 2009; Cameron et al. 2011).³ However, Sarol (2014)⁴ documented a price reduction of these medicines as a result of the MDRP and GMAP programs in 2009 and 2010. For instance, the price of originator medicines⁵ went down on average by 42.3 percent. Even the prices of the highest-priced and lowest-priced generic medicines also went down at the average rate of 27 percent.

The study by Clarete (2017) using medicine prices from 2006 to 2015 corroborates the findings of Sarol (2014). Figure 1 charts the change in average price of medicines by type of manufacturer, weighted by their respective shares in total quantity of medicines sold each year.

The decline of originator medicine prices was relatively large because in 2009 when their medicines were cut they used to have the largest share in the local medicine market.

Through the years, they lost it to generics. In contrast, while the prices of generics also declined, albeit by a lower rate in most of 2006–2015, their market shares increased. The higher shares offset the fall of the prices of generics (Figure 1).

The market shares shifted significantly from originator medicines to generics between 2006 and 2015 (Figure 2). The market share of originator medicines had declined from 62.3 percent in 2006 to only 22.7 percent in 2015. The gainers are the generic medicines, whose respective market shares in 2015 reached 33.4 percent for unbranded and 43.8 percent for the branded generics.

Through the years, according to former DOH Secretary Manuel Dayrit, the government had provided the market infrastructure for generic medicines in public health facilities and village pharmacies. Recently, its effort got a big boost from several private companies, which invested in retailing generic medicines. Together, these measures pushed the access to and acceptability of generic medicines in the country.

³ The Cameron et al. study makes use of the data of the WHO and Health Action International Network surveys in the Philippines. All the assessments on the government programs and policies such as the price capping of medicines share the same observation of high medicine prices in the country (CLD 2010; Sarol 2014).

⁴ Using price data from two related DOH-commissioned surveys in 2009 and 2011.

⁵ An originator medicine is introduced and sold in the market by a multinational company that did the research and clinical trials on the active ingredient in it. Other manufacturers produce their respective generic versions of the medicine once its active ingredient is off-patent. These generic medicines are sold in the market with (branded) or without a brand (unbranded generic).

Table 1. List of medicines (molecules) covered by the MDRP and GMAP

Maximum Drug Retail Prices		Government Mediated Access Prices		
<i>Antihypertensive</i>	<i>Opioid analgesic</i>	<i>Antianginal</i>	<i>Antipsychotic</i>	<i>Antifungal</i>
Amlodipine (including its S-isomer and all salt form)	Fentanyl (as citrate)	Trimetazidine HCl	Clozapine	Miconazole
<i>Anticholesterol</i>	<i>Antidiabetic</i>	<i>Anti-thrombotic</i>	<i>Antiviral</i>	Tolnaftate
Atorvastatin	Gilbenclamide	Clopidogrel	Clevudine	<i>Vitamins and Mineral</i>
<i>Antibiotic/Antibacterial</i>	<i>Neuroprotective</i>	<i>Antibacterial</i>	<i>Antibiotic/Antibacterial</i>	Multivitamins
Azithromycin and all its salt form	Citicoline	Piperacillin + Tazobactam	Levofloxacin	<i>Dialysates/Dialysis Solutions and Medical Devices</i>
<i>Antineoplastics/Anticancer</i>	<i>Antithyroid</i>	Co-amoxiclav (Amoxicillin + Clavulanic acid)	Oseltamivir	Hemodialysis Acid Concentrate
Cytarabine	Thiamazole (Methimazole)	<i>Antiprotozoal</i>	Salbutamol	Hemodialysis Acid Concentrate with Potassium
Doxorubicin and all its salt form	<i>Antiallergy</i>	Metronidazole	Salmeterol + Fluticasone	Hemodialysis Acid Concentrate without Potassium
	<i>Eye preparations</i>	<i>Anticholesterol</i>	<i>Anticancer</i>	Hemodialysis Acid Concentrate
	Betaxolol	Simvastatin	Megestrol Acetate	Peritoneal Dialysis Solution with 1.5 percent Dextrose
	Ciprofloxacin	<i>Antiinflammatory/ Pain reliever</i>	Ifosfamide	Peritoneal Dialysis Solution with 4.5 percent Dextrose
	Pilocarpine	Diclofenac	Mitomycin	Sodium Bicarbonate
<i>Antibiotic/Anti-infective</i>	<i>Antibiotic/Anti-infective</i>	Meloxicam	Eriotinib	Sodium Bicarbonate with Sodium Chloride
	Cefalexin	<i>Anticoagulant</i>	Tamoxifen	Duosol without Potassium
	Clarithromycin	Warfarin	Lapatinib	CA-HP Dialyzer Models
<i>Hepatic protector</i>	<i>Hepatic protector</i>	Nadroparin	Goserelin	110,130,150,170, 210
	Glucometamine + Glucodiamine + Nicotinamide Ascorbate	<i>Antinflammatory/ Antipruritic</i>	L-Asparaginase	
<i>Antihypertensive</i>	<i>Antihypertensive</i>	Betamethasone	Bleomycin	
	Sotalol	<i>Antihypercholesterolemia</i>	Carboplatin	
	Losartan	Ezetimibe	Cisplatin	
	Telmisartan	Ezetimibe + Simvastatin	Cyclophosphamide	
	Telmisartan + Hydrochlorothiazide	<i>Medicine for bladder and prostate disorders</i>	Etoposide	
	Irbesartan	Dutasteride	Mercaptopurine	
	Irbesartan + Hydrochlorothiazide	<i>Antidepressant</i>	Methotrexate sodium	
	Losartan + Hydrochlorothiazide	Paroxetine	Mesna (adjunct to therapy)	
	Felodipine + Metoprolol			

Source: National Center for Pharmaceutical Access Management (2014)

A medicine price index was computed with market shares as weights to summarize how medicines prices moved relative to their levels in 2006. It incorporates all the medicines regardless of the type of manufacturer. Through this computation, this study found that medicines prices dropped from 100 percent in 2006 to 53.18 percent in 2015 (Figure 3).

This study also observed the effect of the MDRP and GMAP and found that the index was 103 in 2008 but fell to 62 in 2010. Interestingly, the price index declined further from 2011 to 2015 indicating tightening competition in the medicines market.

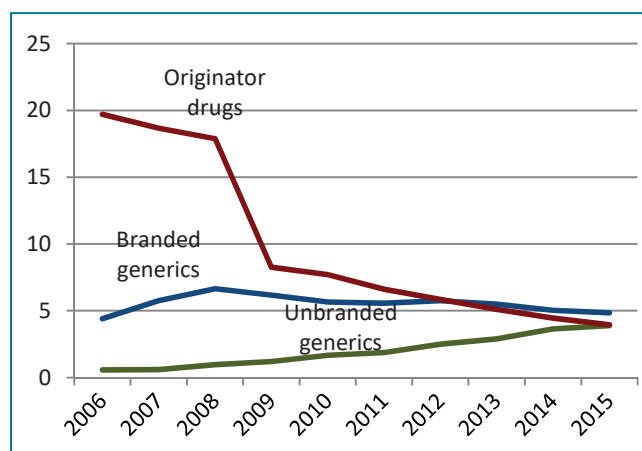
Medicines prices remain unaffordable

In 2010, the Center for Legislative Development (CLD) conducted a survey on the reach of the benefits of the MDRP and the GMAP programs through purposive sampling in six barangays in Caloocan, Manila, and Quezon Cities.

CLD (2010, p.3) observed that despite the drop in the prices of medicines, the “poor still find it difficult to buy the number and quality of drugs they need to cure or control their illnesses.” It also noted the uneven access of the respondents or their communities to medical doctors as a result of the lack of doctors and limited income (CLD 2010).

CLD (2010) found that only 15 out of the 600 respondents said they can afford the medicines they need in treatment packs, as prescribed. The rest afford medicines at

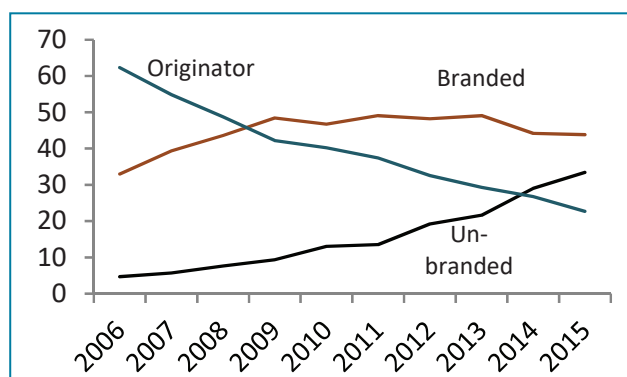
Figure 1. Average prices of medicines by type of manufacturer, 2006–2015



Note: Measured in PHP per counting unit (CU)

Source: IQVIA, <https://www.iqvia.com/>

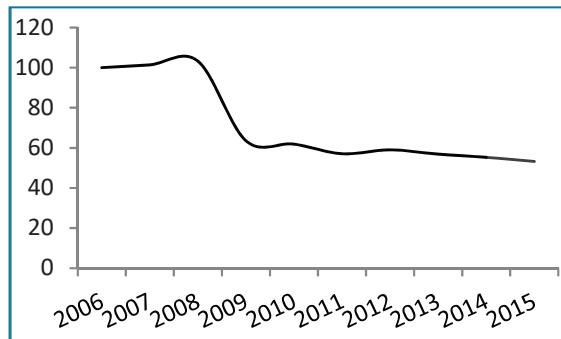
Figure 2. Units of medicines (in million) sold by type of manufacturer, 2006–2015



Source: IQVIA, <https://www.iqvia.com/>

treatment levels. Nearly half or 297 out of 600 respondents said they only have seldom access to unbranded generic medicines, and 81 said the same for branded.

This study shares a similar observation using affordability indices of medicines. A medicine is considered affordable if the cost of its treatment pack is no more than

Figure 3. Medicines price index (2006=100)

Source: Authors' computation based from data presented in Figures 1 and 2

the day's salary of the lowest government worker (Cameron et al. 2011). Health Action International Network (2009) noted that 26 out of 32 treatment packs were considered unaffordable before the MDRP/GMAP.

How did price capping change that? The respective costs of the same treatment packs were reduced using the estimated average price reduction of medicines for the period 2008–2011. Out of the 32 types of treatment

packs, affordability improved in only 9 more types of medicines. The majority of the medicines in Table 2 remained unaffordable.

External reference pricing

The MDRP- and GMAP-enabled medicine price capping is motivated by the observation that the local medicine prices are higher than the international or external reference prices. External reference prices (ERPs) of medicines are prices paid by the public sector in other countries.

The WHO set guidelines on ERPs, which may be used as benchmarks in public procurement of medicines or in capping medicines prices (Box 1). The assumption of ERP is that the prices in reference countries are somehow right, appropriate, or fair.

More importantly, the WHO advises countries to properly compare medicines prices. The ERPs to which local prices are compared are

Table 2. Affordability of medicines: Before and after MDRP/GMAP

	Glibenclamide	Metformin	Captopril	Simvastatin	Diclofenac	Omeprazole	Ranitidine	Ciprofloxacin	Amoxicillin
	Before MDRP/GMAP								
ORI	2.4	3.6	7.5	3.4	4.8	15.4	7.6	3.9	0.8
HPG	2.1	2.3		3.4	2.6	4.2	3.2	1.9	
LPG	1.1	1.4	1.9	2.1	1.1	3.2	2.1	1.3	
Public	0.4	1.0	1.1	1.3	1.1	0.9	0.9	0.3	
	After MDRP/GMAP								
ORI	1.24	1.87	3.91	1.77	2.52	8.08	3.97	2.02	0.43
HPG	1.73	1.82		1.73	1.73	1.73	1.73	1.73	
LPG	0.79	1.04	1.38	0.79	0.79	0.79	0.79	0.79	
Public	0.32	0.71	0.79	0.32	0.79	0.32	0.67	0.19	

MDRP = maximum drug retail prices; GMAP = government mediated access prices; ORI = originator; HPG = highest-priced generic; LPG = lowest priced generic
Source: Affordability indices before MDRP/GMAP, HAIN (2009); after MDRP/GMAP, Authors

gathered by the Management Science for Health for the WHO.

However, while the WHO had compiled country and international benchmark prices of medicines in doing the price comparisons, it did not make adjustments for differences in time, exchange rate, policies, and other factors between countries (Cameron et al. 2011). This casts doubt on the validity of the price premia of medicines in the Philippines over international prices.

In policy discussions on prices of medicines, the Philippine government compares the local prices with those of Thailand and India and Thailand.

Policymakers have recognized the lower medicine prices in India than in the Philippines. According to Ubial (2016), for instance, the prices in India can be 30 percent to 50 percent lower than local prices of medicines. Because of this, the Cheaper Medicines Act authorized the government through the Philippine International Trading Corporation to directly import medicines from India and make them available to lower-income households through village pharmacies.

One factor behind the lower medicine prices in India is the home market effect (Box 2). Pharmaceutical manufacturing tends to require lumpy capital investments. As such, the average manufacturing cost can decline with the volume of medicines produced, as

Box 1. WHO guidelines on external reference prices

1. Countries should consider using external reference pricing as a method for negotiating or benchmarking the price of a medicine.
2. Countries should consider using external reference pricing as part of an overall strategy, in combination with other methods, for setting the price of a medicine.
3. In developing an external reference pricing system, countries should define transparent methods and processes to be used.
4. Countries/payers should select countries as comparison to use for ERP based on economic status, pharmaceutical pricing systems in place, the publication of actual versus negotiated or concealed prices, exact comparator products supplied, and similar burden of disease.

Source: World Health Organization (2015)

Box 2. Home market effect

India's relatively low prices of medicines partly illustrate the home market effect in trade theory. Krugman (1980) claimed that if the home market is large and international transport costs are very high, manufacturers would tend to concentrate producing for the local market to save on transport costs.

The large home market combined with strong scale economies in production allow manufacturers to bring down average costs of the product, in this case medicines.

Source: Clarete (2017)

the large fixed upfront capital cost is spread to a larger volume of output. Because India is the second most populous country in the world, a large home market for medicines may have given it the edge over other countries like the Philippines.

While the Philippines is potentially a large home market as well, at least one in every five Filipinos do not have the purchasing power, rendering the effective national demand for medicines low. Clearly, a large population may not be enough to replicate an India. The government may consider injecting significant purchasing power in the local market to deepen and diversify the local medicine markets. The market may then attract investments to locally produce generic medicines and realize scale economies.

The difference in policies is also another factor one should consider when comparing medicine prices between countries. In the Philippines, the private sector is the larger player in the health-care industry. As such, OOP accounts for 85 percent of expenditures on medicines in 2016. In Thailand, the public sector has the larger presence, making OOP expense on medicines low. With large public procurement of medicines, the cost of medicines to the public sector can be significantly reduced due to lower average transactions cost.

Generics Act

An important stride to overcoming barriers to medicines access is increased competition in the domestic medicines market. After three decades, Republic Act No. 6675 or the Generics Act of 1988 has produced the generics manufacturers, which gave innovators tough competition forcing them to adjust down their prices to defend their market share. The law required the

government to promote generics medicines and gave manufacturers thereof a market of their products in the medicines program funded by the public sector.

Clearly, the emerging pattern is increased competition in the local medicine market. In fact, the government did not have to regulate medicine prices down as the market share of generics had already been rising even before the MDRP and the GMAP (Figure 2). Increasing competition forces both originator and generic manufacturers to lower their own medicine prices to compete with each other and defend their market shares.

The competition would even be more vibrant if the government can deepen the medicine markets in the country through increased public spending on medicines.

Concluding remarks

High medicine prices are not the limiting factor to medicine access in the Philippines. While medicine prices did fall, the demand response to lower prices was low and did not indicate expanded access. At the very least, the market increased in step with the growth of national income.

One would have expected stronger growth of demand for medicines if lower medicine prices were an effective strategy for achieving UHC.

Could the medicine price index (Figure 3) have fallen were it not for the MDRP and the



Given the high out-of-pocket spending on health care in the Philippines, access to quality health care without incurring financial hardship continues to be an aspiration for many Filipinos. To address this problem, this study urges the government to consider measures to promote competition and improve access to medicines in the country, particularly the explicit allocation for medicines in case rates of the Philippine Health Insurance Corporation. (Photo by World Bank/Flickr)


GMAP measures? No doubt it could, especially because the measures cover the subset of medicines analyzed in this study. However, price capping is not necessary for prices to fall as they can actually drop with increased competition in the local medicine market.

In the absence of generic medicines, the index in Figure 3 may have not fallen as much, from 100 percent in 2006 to 53 percent in 2015. The experience may then be that increased competition is necessary for prices to fall and make medicines more accessible to the poor. Clearly, the Generics Act is more effective

than the Cheaper Medicines Law in bringing medicine prices down.

Deepening the local medicine market is crucial to make the competition more effective in lowering prices. Given that the government is the stakeholder that can effectively bring up the purchasing capacity, it should expand the pooled procurement of medicines to attract more suppliers in the market. Such action gives the public sector leverage in getting medicines prices further down. The government can then distribute the medicines it procures to the poorest population who

do not even have the purchasing power to acquire medicines even at reduced prices.

The government can also consider other measures to promote competition and improve access to medicines, such as (a) explicit allocation for medicines in case rates of the Philippine Health Insurance Corporation (PhilHealth), (b) extension of PhilHealth coverage to outpatient medicine prescriptions initially in public health facilities and eventually in accredited private sector drug outlets, (c) pooling of financial assistance from state-owned corporations and agencies for catastrophic illnesses, (d) provision of incentives to local government units to invest more in primary health care with medicines an integral part of their program, and (d) tiered pricing of medicines. 

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