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FOR INCLUSIVE GROWTH UNIVERSAL HEALTH CARE LOWER DRUGS PRICES IS A MANDATORY REQUIREMENT

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ABSTRACT

For universal healthcare, lower drug prices to the purchasing power of consumers in different geographical or socio-economic segments of the country could potentially be a very effective way to improve access to medicines for people living in low and middle-income groups. A well-implemented differential pricing system could also lead to universal availability of health care. The current study is the review of the sixteen research work on the said subject.

Keywords: *Lower drug price, access to medicine,*

INTRODUCTION

As per the OECD Health Data 2005, user charges consistently lower health care use and, if carefully designed, can guide patients towards cost-effective care, they do not lead to long-term control of pharmaceutical spending and seem unlikely to contain total spending on health (not least because they can threaten patients' health). In spite of research suggesting that user charges are unlikely to contribute to health policy goals such as efficiency and equity, many countries charge patients for some health services, most commonly for prescription drugs. The universal application of prescription drug charges may reflect anxiety about the rapid growth of pharmaceutical budgets, although many of these countries applied prescription drug charges before rising drug budgets became a pressing policy matter.

Culyer el at (1996) asks what relevance allocative efficiency has for policy making in health care. If it is to be understood as a normative concept, then we must assume either that the distributional and health consequences are of no importance or, if they are important, that all individuals in a given society share the same level of income, the same tastes and preferences, and the same risk of ill health, etc. But neither assumption reflects reality.

Williams A (1997) opines that , an efficient allocation of health care resources would be one that maximizes health gain, where health gain is measured in a standardized manner (for example, through quality-adjusted life years).

As per the WHR study (2015), Equity in finance requires richer people to pay more for health care, as a proportion of their income, than poorer people. Equity of access to health care implies access to health care based on need rather than ability to pay. Because equity of access is difficult to measure, most studies employ equal use of health care as a proxy for equal access, as we do in our concluding discussion.

According to Bate et al (2007), Economic arguments in favour of user charges are based on the concept of allocative efficiency, which deems resources to be efficiently allocated when people are willing to pay for a commodity at a price that reflects the marginal cost of producing the commodity. This has two implications. First, providing an unsafe or ineffective commodity to those willing to pay for it is efficient, whereas providing an effective and beneficial commodity to those unable to pay for it is inefficient. Second only those who are willing to pay should have access to a particular commodity.

Pauly (1968) opines that from an economic perspective, any reduction in the use of health care following the introduction of user charges contributes to allocative efficiency, regardless of the distributional or health consequences. If the presence of health insurance means that health care is free at the point of use, the consumption of health care will not reflect the marginal costs of its production, leading to welfare loss since scarce resources might be better spent on producing and consuming other commodities. User charges redress this loss by reinstating price: those willing to pay the price may use health care, those unable to pay must do without.

Nair KV et al (2003) have seen that chronic diseases are setting in early, a large majority of the population will be still working, and this is going to increase the burden on the patients. Pharma companies will have to work around a pricing strategy that will try and reduce the prices appropriately, so that they can rely more on volumes, with larger population suffering from chronic diseases. The chances of 'penetration strategy' working successfully would be determined by 'higher volumes through lower prices. Some MNCS have looked at differential pricing while launching their global drugs in India.

A report by PWC (2012) suggest that Creating awareness about the disease and its implications will improve the diagnosis rate and improved efforts from companies through key stakeholders will improve compliance drastically. Improved compliance will dramatically increase sales of some drugs and, in turn, will drive growth for the companies. Companies will have to work closely with key stakeholders like the payers and providers to improve patient compliance especially in speciality and super-speciality segments. In a country like India, the diagnosis rate is low and a compliance rate is lower in the treatment of almost all chronic diseases.

Wilson P (2010) talk about trends, prompting the pharmaceutical industry to pay more attention to differential pricing, such as economic and demographic growth in some low and middle-income markets, which has increased the potential market size of many low and middle income countries; greater recognition by the pharmaceutical manufacturers and their investors of the social responsibilities; stronger global advocacy for access to medicines, and growing competition from generic manufacturers in emerging markets.

Steinbrook R (2007) study points that that differential pricing allows pharmaceutical companies to signal that their pricing policies are socially responsible and consistent with their obligations to society and not just geared towards maximizing profits. In addition, differential pricing on select drugs opens opportunities to serve low and middle-income markets and creates economies of scope for pharmaceutical companies.

Jayashree Dubey et al (2010) opines that in a country like India, the diagnosis rate is low and a compliance rate is lower in the treatment of almost all chronic diseases. Pharmaceutical companies will have to work closely with key stakeholders like the doctors and providers to improve patient compliance especially in speciality and super-speciality segments. Creating awareness about the disease and its implications will improve the diagnosis rate and improved efforts from companies through key stakeholders will improve compliance drastically. Improved compliance will dramatically increase sales of some drugs and, in turn, will drive growth for the companies.

Flynn S., (2009), suggests that differential pricing would lead to lowering the prices in many low and middle-income countries and is based on the prerequisite that price reduction is likely to bring in more sales. This creates pressure upon the entire organization to do higher volume of business to sustain profitability. Large pharmaceutical companies are not necessarily organized to operate their distribution business in developing countries with thin margins. Pharmaceutical distribution in developing countries is organized slightly differently as compared to OECD countries. On one hand government-run health programs buy large volumes of product through a tendering process. On the other hand, small private sector retail pharmacies that cannot keep a large number of medicines in stock due to capital constraints rely on an extensive network of sub wholesalers instead of buying directly from large manufacturer-appointed distributors. This leads to the existence of multiple third parties between the manufacturer and the dispensing pharmacists; increases the retail price due to multiple distribution markups' and does not leave enough transparency to prevent product diversion in a robust manner.

A study by Jaya PP (2010) points out that Indian companies have also been partnering with MNCs in emerging markets. There is also an increasing trend among multinational pharmaceutical companies for partnering in the domestic market, where marketing and distribution network of Indian companies and the product portfolio of multinational

pharmaceutical companies is being leveraged upon. Such alliances benefit from the R&D (formulation development) and manufacturing capabilities of the Indian partners and the extensive marketing and distribution footprint of the MNCs in those markets. Hence, India should leverage its strengths in the supply of low-cost, quality medicines across the world and partner with foreign companies to drive growth and play a larger role in global pharma market.

Study by Jha, Ravinder (2007) points out that giving low priced drugs only to the public sector is not enough as the poor also seek treatment in a private sector consisting of private hospitals, licensed drug sellers, private nursing, and informal channels. Although many such channels are directed towards the poor they are very fragmented. Pharmaceutical companies have shown willingness to provide such systems with lower priced product if they can ensure that the product is only used in the market for which it is intended. However, the excessive fragmentation of these channels implies that there is a need to control directly the distribution of the product to the point of final consumption. Also, the transaction costs of contracting such pricing arrangements with multiple smaller players need to be addressed by the statutory authorities. A majority of the rural poor for whom lower pricing strategies can be created live in areas which pose enormous distributional challenges. As a result, pharmaceutical companies have so far limited their preferential lower pricing programs to the public sector or the NGO sector.

Scherer (2004) suggest that Pharmaceutical companies should provide lower prices to health systems that have demonstrated their reach to the poor and have robust systems in place to guarantee monitoring and performance evaluation. Novel technology solutions that reduce the transaction cost of dealing with small fragmented markets should be utilized to ensure that smaller distribution/retail players who are targeting the poor segments can have access to lower prices.

CONCLUSION

Lower Pharmaceutical pricing can enhance access to medicines, improve quality of medicines and achieve higher profits for pharmaceutical manufacturers. However, lower pricing can be sustainable only if statutory bodies and the government proactively align the incentives of the different stakeholders: pharmaceutical manufacturers, national governments, end patients and civil society organizations. Pharmaceutical companies would want become more open to lower pricing if the risks of physical arbitrage could be managed collectively together with national governments, statutory authorities and NGOs. The central governments has a key role to play in providing the political will and objectively determined reimbursement policies to enable lower pharma pricing.

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