

Chapter 4

Pricing Wars and Policy Evasion

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Introduction: The Illusion of Affordability

India's pharmaceutical industry is frequently praised for its role in making drugs affordable—not just at home, but across the Global South. Yet, a closer look reveals a fragmented and opaque system of pricing, one that **frequently favors profit over patients**. In India, **drug prices can vary 300–1000% between brands**, and **many essential medicines remain unaffordable despite being off-patent** [1].

This chapter examines how the **Drug Price Control Order (DPCO)** is routinely **evaded or manipulated**, and how strategies like **brand proliferation**, **evergreening**, and **non-compliance** allow pharmaceutical companies to bypass the intent of affordability policies.

1. DPCO and NPPA: The Price Control Framework

India's principal drug pricing law is the **Drug Price Control Order (DPCO)**, enforced by the **National Pharmaceutical Pricing Authority (NPPA)** under the **Essential Commodities Act**.

Key features of DPCO 2013 include:

- A **ceiling price** for drugs listed in the **National List of Essential Medicines (NLEM)**
- Price calculated using **market-based pricing**: Average of all brands with $\geq 1\%$ market share

- Annual price hikes linked to the **Wholesale Price Index (WPI)**
- **Fixed-dose combinations (FDCs)** subject to special review

| **Table 1: Drug Price Control at a Glance (2022)** |

Total formulations under price control (NLEM)	~872
% of domestic pharma under control (value)	~18%
Max WPI-linked price hike allowed (2023)	12.12% [highest ever]
Enforcement agency	NPPA

Source: NPPA Annual Report 2022 [2]

Despite these controls, **the majority of the ₹2.8 lakh crore pharma market operates outside DPCO coverage** [3].

2. The Loopholes in the System

Manufacturers regularly exploit systemic gaps in DPCO coverage:

a) Evergreening and Reformulation

Companies introduce **slightly modified versions** of essential drugs to avoid price control.

- E.g. Cipla launched **modified-release** formulations of NLEM drugs like salbutamol
- Aurobindo and others launched **combination variants** of DPCO-listed antibiotics

These variants are **technically ‘new drugs’**, so **DPCO ceilings don’t apply immediately**

b) Brand Proliferation and Market Fragmentation

With **over 60,000 brands** for 60,000 molecules, companies create pricing opacity.

- Example: The **same paracetamol 500mg** can cost:
 - ₹0.30 (generic bulk pack)
 - ₹1.50 (branded generic)

- ₹3.00+ (premium brand)

| **Table 2: Price Variation for Common Drugs (2023)** |

Drug (Dose)	Lowest Price	Highest Brand Price	Variation (%)
Paracetamol (500mg)	₹0.30	₹3.20	966%
Atorvastatin (10mg)	₹1.90	₹10.50	452%
Pantoprazole (40mg)	₹2.10	₹9.80	367%

Source: NPPA Price Monitoring Cell [4].

3. DPCO Evasion through “New Drug” Clause

According to Rule 122-E of the **Drugs and Cosmetics Rules**, any drug formulation introduced within 4 years of central approval is considered a “**new drug**”, exempt from DPCO until reviewed.

Companies use this window to:

- **Launch new combinations** (e.g., antibiotics + probiotics)
- Rebrand old molecules with **new salt forms or dosages**
- Delay NPPA scrutiny through litigation

In 2018, nearly **40% of top-selling drugs were new combinations** not under price control [5]

4. Lack of Monitoring and Weak Enforcement

Although NPPA publishes ceiling prices and penalizes overcharging, enforcement is patchy:

| **Table 3: NPPA Enforcement Summary (2015–2022)** |

Metric	Total
Overcharging cases filed	2,206
Amount demanded (penalty)	₹7,300 crore
Actual recovery	₹790 crore (~10.8%)

Source: NPPA RTI Disclosures 2022 [6]

Many firms contest these cases in court, delaying penalty collection. Further, **State Drug Controllers**—tasked with enforcing DPCO compliance—rarely conduct price audits.

In retail, **chemists continue to sell unregulated brands with high trade margins**, making NLEM enforcement toothless at the counter level.

5. High Trade Margins: Profits over Affordability

Margins offered to distributors and chemists are often excessive, especially for non-scheduled drugs:

| **Table 4: Trade Margins in Indian Pharma** |

Category	Manufacturer Margin	Chemist/Distributor Margin
Scheduled (NLEM) drugs	~16%	≤16%
Non-scheduled branded drugs	50–70%	20–30%
Nutraceuticals, vitamins	Up to 100%	40–60%

Source: AIOCD AWACS Report 2021 [7]

Manufacturers **deliberately inflate MRPs** to accommodate high trade margins – prioritizing **sales incentives** over patient access.

6. The Chemist–Company–Doctor Triangle

High prices are also maintained by **perverse incentives**:

- **Doctors** receive gifts, foreign trips, and sponsorships to prescribe high-MRP brands
- **Chemists** push higher-margin products
- **Companies** resist DPCO coverage for their bestsellers

This results in a **dual market**:

- **Generic name is affordable** but rarely prescribed
- **Brand name is expensive** but widely pushed

In many Tier 2–3 cities, **government-set ceiling prices are irrelevant** because patients **rarely encounter them** at pharmacies.

7. NPPA Initiatives That Helped – But Not Enough

a) Price Monitoring Resource Units (PMRUs)

Set up in **21 states** to monitor local prices and availability. However, most are underfunded and lack legal enforcement powers.

b) Trade Margin Rationalisation (TMR)

2019 pilot capped **margins on anti-cancer drugs** at 30%:

- Resulted in **average 85% price drop** in 390 cancer brands [8]
- Proposal to extend TMR to all drugs is **under industry pressure**

c) Jan Aushadhi Stores (JAS)

Launched to supply **generic medicines at 50–90% lower cost**.

| **Table 5: Jan Aushadhi Scheme Performance (2023)** |

Metric	Value
Total Stores	9,200+
Drugs available	1,616
Average savings to patients	₹4,000 crore
Awareness among doctors	<40% (low usage)

Source: BPPI Annual Report 2023 [9]

Despite success, **most doctors do not prescribe Jan Aushadhi drugs**, and **chemists rarely promote them**, fearing margin losses.

8. Litigation and Pharma Pushback

Pharmaceutical companies **frequently file writ petitions** against NPPA orders. For example:

- **GlaxoSmithKline, Abbott, and Novartis** challenged price control on core antibiotics
- **High Courts** have granted interim relief, stalling enforcement
- **Industry lobbies like IPA and OPPI** argue DPCO harms “innovation and investment”

As a result, NPPA often **withdraws or delays price control notifications** under pressure, especially for combination or injectables.

9. The Cost of Non-Compliance: Human Impact

For millions of Indians, irrational drug pricing means:

- **Skipping doses or abandoning treatment**
- **Pushing families into debt for chronic conditions**
- **Being sold expensive brands with no added benefit**

A 2021 study by PHFI found **56% of Indian households incur catastrophic health expenditure** on medicines alone [10].

10. What Real Reform Could Look Like

Experts suggest a shift from **selective price control to system-wide transparency**, such as:

- Expanding **Trade Margin Rationalisation** beyond cancer
- Real-time **drug price dashboards** at state level
- Mandatory **generic name prescriptions** (and enforced substitution)
- Penalizing firms for **non-compliance and price rigging**
- **Procurement-based pricing** for government schemes

Only a **patient-first pricing ecosystem** can reverse the current distortion where **market success depends more on marketing than merit**.

Conclusion: Cost Without Care

India's drug pricing ecosystem is a paradox. While medicines are among the cheapest globally, they remain unaffordable to millions domestically. The system—designed to protect patients—is **routinely gamed by powerful pharma lobbies**, with **weak enforcement and policy fatigue compounding the crisis**.

What's needed is **not just price caps**, but a **culture of ethical pricing, transparency, and accountability**—backed by legal power and political will.

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