

Should the prices of patented pharmaceuticals include R&D contributions in settings such as the UK, the EU and the US?

In conditions of market failure, such as those that arguably exist in poorer parts of Africa, Asia and Latin America, there is (despite widespread disease) little direct incentive for the private sector research industry to invest in the development of new medicines designed only for those markets. This is because the intended consumers will not, without the intervention of third party payers, be able to afford such products at prices sufficient to provide a viable return. Indeed, they may not even be able to purchase (or, given the labour costs of medical and pharmaceutical care, to make appropriate use of such medicines) at the marginal production and supply cost.

In circumstances like these it is reasonable to argue that research funding should be separated from that of production and supply. Third party payers like, say, the Gates Foundation, Governments and agencies like WHO and UNICEF might with good reason seek to stimulate two markets, one for specified preventive and therapeutic innovations and one for the delivery of effective treatment packages (ie for drugs supply at prices set at as close to the marginal production cost as is sustainable, plus immediate service) to vulnerable populations.

HIV treatment is a special case, where in the face of a new global pandemic affecting both rich and poor populations new products were priced at levels affordable in the context of rich world health care delivery (ie to include R&D costs and/or investment returns sufficient to justify continuing highly risked research expenditures). As was obvious from a very early stage in the pandemic, these were unaffordable in the areas of greatest need. Hence special intervention before the normal processes of patent expiry and mass commodity level production had occurred was required, leading to considerable controversy.

It is in essence the experience of HIV drug supply in the poor world which lies behind much of the current argument for dis-linking medicines research funding and drug supply costs in the rich world, albeit that conditions such as malaria present to a degree comparable challenges. However, the view taken here is that the prices of commercially supplied patented medicines should in normally functioning markets continue to reflect the levels of incentive needed to drive not only an adequate supply of existing treatments, but also investment in ongoing innovation.

Given that there is already substantial public funding for medicines research to institutions such as Universities and public sector hospitals and laboratories, the advantages of continuing 'integrated' private sector pharmaceutical pricing in areas such as the EU, the US and Japan relate in essence to the power of (albeit modified) market forces to inform (translational) research prioritisation, and maintain an adequate level of urgency in the process of getting new and improved products to their potential consumers, notwithstanding concerns in areas such as safety and cost. There is a large body of economic theory and research that indicates that undue separation of the production and delivery process ('generic' or commodity supply) from that of innovation,

and the removal of direct market incentives from the latter, could well lead to stagnation rather than enhanced welfare generation.

Some commentators may argue that as global demographic and epidemiological transition continue, and poorer populations are increasingly exposed to patterns of illness like those experienced in the 'rich world', an increasing number of HIV like situations will occur. But this ignores the reality that HIV infection was an acute, in many ways once-off, event, while the build up of post-transitional disease patterns is part of a slower, in itself 'chronic', historical continuum. This means that there should be time for innovations in areas such as vascular disease and cancer care that have been developed via richer community market driven investments to via become normally available as low cost generics, well before 'poor world' demand peaks.

David Taylor, Feb 2010