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# There are simple ways governments can better get medicine to the world's poor, but destroying patent rights won't do it

By Philip Stevens and Nilanjan Banik, Special to Financial Post

*Philip Stevens and Nilanjan Banik: These are practical areas that could be reformed now. The delinkage agenda under discussion in Geneva, while...*

The cost of medicines was on the agenda last week at the World Health Organization's annual policy meeting, the World Health Assembly, in Geneva.

NGOs and certain middle-income countries argued that market-based drug development - reliant on intellectual property rights (IPRs) as its primary incentive - makes medicines too expensive. It fails, they say, to provide cures for those who are most in need but who can't pay, such as people in developing countries. NGOs talked excitedly about a new model for drug development, in which research and development costs are "delinked" from the final price of a drug.

One of the main "delinkage" proposals is a massive increase in government funding or subsidy of clinical trials, to be undertaken by the public sector, academia or other non-profit organizations. In return for these subsidies, R&D bodies would forego their IPRs, allowing new taxpayer-funded drugs to be distributed very cheaply on their release. Policy-makers could prioritize research on the most pressing diseases.

Would a world of publicly funded R&D usher in a new era of cheap medicines?

The idea's proponents say that most new medicines already come from the public sector. In a 2015 commentary in The New York Times, Nobel laureate economist Joseph Stiglitz wrote, "As it is, most of the important innovations come out of our universities and research centers, like the National Institutes of Health, funded by government and foundations."

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It is certainly true that in the United States, the federal government is the biggest funder of basic research, via the National Institutes of Health, which disperses grants to research institutions for early-stage research. But it is a leap to argue that because publicly funded research institutes play an important role in early research, they also have the skills, resources and motivation to undertake its commercialization.

Universities simply don't have the specialist skills and facilities - such as chemical formulation and toxicity testing - to navigate a drug through the clinical trials required by regulators to approve a drug as safe for the market.

Those drugs with publicly funded origins typically come from universities taking advantage of IP laws (such as the Bayh–Dole Act in the United States) to licence their early discoveries to the private sector for commercialization.

Countries such as China now also have such legislation, hoping it will bolster local innovative industries, while similar proposals are under discussion in India.

Asking universities to move from basic research into fully fledged drug commercialization would require enormous subsidies to build technical and commercial capacity, and manufacturing and distribution systems. Universities would be diverted from their core purpose - to advance knowledge.

As it stands, private industry rightly shoulders most of the financial burden and risk of drug development. IPRs - particularly patents - are the key incentive, because they give investors certainty that they can fund risky projects while standing a good chance of getting a return.

They are just as important for small R&D companies as they are for large ones: Evidence shows that the existence of a patent signals to venture capitalists that an early drug idea has potential, helping them to make more informed investment decisions.

Removing patents from the innovation equation without a workable replacement would be hugely disruptive. The damage would be worse if policy-makers committed to a delinkage agenda are pinning their hopes on an ill-equipped public sector and academia to conduct considerably more drug R&D.

Instead of utopian attempts to effectively nationalize drug R&D, policy-makers concerned about innovation and access to medicines should focus on more practical solutions.

The mandatory clinical trials process is where most drug development costs are incurred, for instance, but regulators have overseen an unwelcome increase in complexity in recent years.

Import tariffs and taxes on drugs remain high in many countries. And too many countries particularly in Asia and Africa have dysfunctional health-care systems that leave patients to shoulder the costs of all their health care, meaning even cheap, old drugs are unaffordable to millions.

These are practical areas that could be reformed now. The delinkage agenda under discussion in Geneva, while well-intentioned, is a distraction.

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