Pharmaceuticals and Global Health Policy:

Medicines, Markets, Manufacturers, and Medical Countermeasures

One-day workshop, 9 June 2016, University of Sussex

systems' discontinuity, evidence was shown that governments' early choices in setting up national

The third presentation examined BARDA's response to the recent Ebola crisis and the way collaborations could be structured to respond to future outbreaks. A vision for a more sustainable response to emerging infectious disease was outlined. It is one that seeks to move past the boom and bust cycle of Research and Development funding and development for outbreak responses by focusing on long term investments in technologies, platforms and institutions required to respond quickly and effectively to the next outbreak. Such efforts must ensure equitable access to developing countries and the pooling of funds to support a long term approach. A mechanism of prioritisation for the allocation of resources has emerged into a two pronged strategy: 'just in case' and 'just in time'. 'Just in case' prioritises pathogens and develops them to the latest stage possible, enabling the rapid scale up to clinical trials should the pathogen emerge. 'Just in time' is a long term project focused on the development of technology platforms such as vaccine delivery to be mobilised in response to an outbreak. There is a third aspect of this approach, which seeks to develop an organisation like BARDA to coordinate efforts in the field and develop drugs on a global scale. Such efforts must also be able to interface with organisations both upstream and downstream. Initial efforts have taken the form of a coalition offering funding to support this business plan.

Panel 2 - The Global Supply of Medicines: TRIPs, Generics, Pharmaceutical Companies Old and New

This second panel explored the global supply of medicines, specifically looking at the post-transition period equilibria in Trade-Related-Intellectual-Property-Rights (TRIPS) in emerging economies, and on new partnerships for the research and development of medicines. Firstly, it analysed the evolution of the political economy of medicine patents, the role of patent implementation and its effect on pharmaceutical products, and the effect of continuity and discontinuity in national patent systems. In the 1970s and 80s the countries of Western Europe and the Organization for Economic Cooperation and Development (OECD) started to allow pharmaceutical patents. This began with the establishment of patent law in the United States, United Kingdom, France and Western Germany in 1970. In understanding the policy choices regarding how and when pharmaceutical patents should be introduced, research has shown that early choices matter, particularly with patent implementation and in understanding the effects of policy choices. A lot of decisions made by countries in the 1990s about how and when they should introduce pharmaceutical patents triggered all sorts of consequent reactions within the state, industry and society. When new issues emerged in the 2000s in relation to what will

response set out to match the political demand with the financial incentives. These partnerships have launched a lot of products and impacted lives positively, though they have considerable limitations. Foremost, they still rely on the idea that we need to incentivise companies to invest in a field that is essentially not commercially interesting.

The third presentation investigated how the rise of countries such as India and China will impact health security and the global supply of medicines. India has come to dominate the global supply of generic medicine, it is the third largest supplier of medicines in the world and is often referred to as the pharmacy of the developing world. The impact new patent regimes may have on this supply of medicines has generated concerns. Questions have also been raised as to the quality of the medicines

asserted that vaccine production is a key element of

The same report also seems to suggest that pharmaceutical companies should be forced to invest in discovering new antibiotics, and then foregoing the potential financial reward from launching them in the markets, in order to keep these new molecules as second or third-line treatment. The report seems to ignore that new antibiotics could be easily reverse engineered and produced by Chinese and Indian pharmaceutical firms. This means that the development of these drugs, if they are to remain efficacious, has to take place within a global agreement on restricted use. Access to antibiotics currently in use must also be just and fair, as well as sustainable, to ensure global and national action. The public expectation of access to antibiotics should be acknowledged in relation to the incentives along the value chain that support the selling of drugs. Access to antibiotics is seen then as a global right and the efficacy of these antibiotics is a global public good which needs to be preserved. A clear tension has emerged in dealing with this issue between individual benefit, saving lives and the global public good, between security and access. Any global agreement must carry out and develop surveillance, antibiotic production and diagnostic technologies with users and local communities in mind. Communities must also be empowered to rethink their right not just to antibiotics but to effective antibiotics. Coalitions must be built that are much broader than those usually developed in global health and must include key attitude makers if it is to be a legitimate movement. By focussing on the issue of governance in this

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