Balancing options for health research and development

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The Member States of the World Health Organization (WHO) have been asked to evaluate a specific proposal by the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG) to create a convention – "the strongest form of international agreement"[1] – to expand funding for medical research.[1,2] The initial proposal has much merit, but its narrow mandate has undermined support among developed countries. Further progress may depend on modifications to the nature of the legal obligations to fund research named in the proposal, among other aspects. Changes to the proposal are necessary and natural as Member States engage in and claim ownership of a new global mechanism to address funding for priority research and development (R&D). But what will remain important are: (i) commitment to high-level ideals of expanding R&D investments in the areas of greatest need, and (ii) a delinking of R&D costs from product prices to simultaneously expand innovation and access.

The CEWG proposal was designed to address a limited set of diseases that predominantly affect developing countries. It aims to promote "the development of health technologies for Type II and Type III diseases as well as the specific needs of developing countries related to Type I diseases".

The primary mechanisms to support such research were an obligation on convention members to invest a certain percentage of national income in R&D, including a fraction to be allocated to a new multilateral pooled funding mechanism. The proposal for a convention also included several other norms, such as a requirement to delink R&D costs from product prices, to enhance the innovative capacity of developing countries and transfer technology to such countries, and to expand access to scientific knowledge.

The CEWG report was widely praised by public health and nongovernmental development organizations[3–5] and received initial support among several developing countries. However, it met with considerable resistance among many high-income countries.[6] Why was the reception among high-income countries so poor? For many, the CEWG proposal was simply a permanent commitment to spend a fixed fraction of a country's gross domestic product on projects of little or no value for their own residents, and to strengthen the role of developing countries as suppliers of high-technology goods. This comes at a time when many developed countries are struggling to control budget deficits, expand domestic employment opportunities and maintain a competitive advantage in high-technology markets.

The decision by the CEWG to limit the benefits of the convention to a narrow set of health-care problems affecting developing countries was designed to make the convention less threatening to the large pharmaceutical companies, which are perceived as anxious to protect global norms for strong intellectual property rights and high prices for new drugs for cancer, diabetes, asthma and other "Type I" diseases with large markets in high-income countries. The CEWG strategy was partly successful in that the International Federation of Pharmaceutical Manufacturers and Associations was publicly generally supportive of the CEWG report during the May 2012 meeting of the World Health Assembly.[7] Unfortunately, the very measures that made the CEWG more attractive to big pharmaceutical companies made it less attractive to residents of high-income countries, including the finance officials being asked to pay and the trade officials protecting domestic competitive advantages.

What could change the dynamics of the negotiations would be to broaden the terms of reference to include any medical research priority that Member States identify. This would include not only Type II and III diseases, but also R&D funding for pre-competitive research, development of new antibiotics, or better and cheaper diagnostics – all areas in which big pharmaceutical companies have signalled support, as well as others more controversial with industry but valued in both developed and developing countries, such as funding for independent clinical trials. Residents and finance officials in all countries would then see an R&D agreement as providing value for money and a solution to health needs they care about.

The CEWG proposal makes reference to a centralized pooled funding mechanism, and this is also controversial. We have proposed competition among pooled funding mechanisms to give donors the freedom to choose one that gives them greater reassurance that money is being spent wisely.[8]

The connection between the new delinkage paradigm and the growing problem of high drug prices is important also. The trend in current trade policy is to promote ever more aggressive intellectual property rights and other measures leading to higher drug prices.[9] If this trajectory is not curtailed, consumers everywhere will face greater barriers to access and financial hardships.[10,11] Consumers and policy-makers can and should view the R&D treaty as a potential mechanism – if not in the beginning, perhaps later – to protect funding for innovation in cases in which governments take steps to protect consumers from high prices.[12,13] Trade policy can become more open to health needs by focusing on R&D funding rather than only on intellectual property rights or high drug prices. ■

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