“Part of how we know the world in global health is shaped by ‘indicatorization’. Just as structural adjustment enables governance at a distance, global health is increasingly monitored through algorithms and statistical and mathematical modelling.”

—Alicia YAMIN

Quote from the article “From Health to Political Economy: ‘How We Know What We Know and Why Intersecting Matters Now” in Intersecting Vol. 1 by Alicia Yamin (Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics at Harvard Law School, Boston, United States of America). Image Source: Wikimedia Commons. About 100 people queuing at a supermarket in Italy during coronavirus outbreak. March 19, 2020. Image by Ian-Art photography. https://de.m.wikipedia.org/wiki/Datei:Ian_Art_Photography_-_Italy_100_people_queuing_at_a_supermarket_during_coronavirus_outbreak_mar-2020.jpg

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A Health Impact Fund

Globalized in 1995 through the TRIPs Agreement,[1] humanity's dominant mechanism for encouraging innovations features 20-year product patents that reward innovators through monopoly markups. As the recent Covid-19 pandemic has shown once more, reliance on this mechanism is morally problematic in the pharmaceutical sector. It excludes the global poor who cannot buy patented treatments at monopoly prices and whose specific health problems are therefore under-researched, and it discourages pharmaceutical firms from fighting diseases at the population level with the aim of slashing their incidence.

These problems can be alleviated by establishing an additional, optional reward mechanism that would enable pharmaceutical originators to swap their monopoly privileges on a patented product for impact rewards. Such an international Health Impact Fund (HIF)[2] would require prices of registered products to be delinked from R&D expenses and limited to the lowest feasible variable costs of manufacture and distribution. This price cap could be determined through a tender among competing contract manufacturers, or the innovator might issue royalty-free licenses for the manufacture and sale of its product.

In exchange, the HIF would make predictable annual distributions that are divided among registered products according to the health gains achieved with them in the preceding year. Each registered product would participate in ten consecutive annual payouts and then go generic. Some version of quality-adjusted life years (QALYs) could be used as a common metric for comparing and aggregating health impact across diverse diseases, therapies, demographic groups, lifestyles, and cultures.

The HIF would create a novel market in which new pharmaceuticals of all kinds could compete in the quest to achieve the most cost-effective health gains. Over time, a stable, self-adjusting reward rate ($/QALY) would emerge. When innovators find it unattractive, registrations dry up and the reward rate rises as older innovations exit at the end of their reward period. When the reward rate is seen as generous, registrations multiply, and the reward rate declines. Such equilibration reassures participating innovators and contributors that the reward rate will be fair and stable. Innovators would find HIF registration especially attractive for new pharmaceuticals with which they expect to be able to generate large cost-effective health gains but only

modest monopoly rents: effective remedies against diseases that are widespread, grave, infectious, and concentrated among poor people. Many HIF-registered pharmaceuticals would be ones that otherwise would not have been developed at all.

Each year, millions suffer and die from diseases that we could treat or prevent with medicines that could be mass-produced quite cheaply. The HIF would end this outrage by creating powerful new incentives to rapidly develop remedies against diseases that are concentrated among the poor, to provide such remedies with ample care at very low prices, and to deploy them strategically to contain, suppress, and ideally to eradicate the target disease. Registrants would gladly share their relevant technology and know-how to this end, and even invest in subsidizing their product to resource-constrained buyers and in promoting optimal use, if and insofar as the increase in impact rewards gained from wider and better use is expected to exceed the cost of the relevant investments.

To leave no one behind, the HIF assigns more value to the lives and health of poor people than what they themselves can afford to pay. Doing so is morally imperative. It is also collectively beneficial, especially with communicable diseases, which would be central to the HIF. By suppressing and ideally eradicating such a disease among the poor, all are safer from the threat it poses, including the threat of new drug-resistant strains, which often emerge in patients who cannot afford to take an expensive drug at full dosage for the full course of treatment.

The HIF would motivate registrants to build, in collaboration with national health systems, international agencies and NGOs, a strong public health strategy around their product. It would do so by taking full account of the health externalities of product deployments: rewarding not merely health gains achieved for treated patients but also realized reductions in the incidence of the target disease. The latter rewards are especially sweet because such health gains are generally highly cost-effective. For example, by making its product accessible rapidly, competently, and universally in one country, an originator may help contain a disease that would otherwise have spread into neighboring countries, thereby achieving health impact in those other countries without having to do any work there at all. Were its all-out effort successful in containing the target disease, this originator would, without further labor, collect health impact rewards from a grateful world.

Monopoly rewards, by contrast, penalize originator efforts at disease curtailment and eradication: as the target disease disappears, so does the market for its remedy. The HIF is useful, then, to motivate originators to fight communicable diseases at the population level. The absence of such incentives heretofore may well be the reason why, with all our scientific sophistication, and all the trillions spent on pharmaceuticals, humanity has only ever managed to

eradicate one single human disease: smallpox, over 40 years ago.

The HIF needs reliable, long-term funding commitments which, at least initially, must come from states. Their contributions would be offset by savings on registered pharmaceuticals and other health care costs (health insurance, national health systems, foreign aid) as well as by health-related gains in economic productivity and associated tax revenues. In addition, the HIF would greatly reduce wasteful originator spending on multiple staggered patenting in many jurisdictions with associated gaming efforts (e.g., evergreening), searching and preventing patent infringements, and mutually-offsetting competitive promotion efforts. Finally, the HIF would also avoid economic deadweight losses, corrupt marketing practices, and counterfeiting: With the genuine quality product widely available at a rock-bottom price, it is not profitable to market fake copies; nor is it necessary to patent the product in all jurisdictions when the HIF recognizes one reputable patent as sufficient for registration.

Contributions to the HIF might be based on Gross National Income, exempting lower-income countries. Should some affluent states decline to contribute, originators should be free to exercise their patent privileges in those states. This exception would give affluent countries an incentive to join. It would also lower innovators' opportunity cost of registration and thereby depress the HIF's endogenous reward rate, making it cheaper to attract a given number of registrations. In this way, the missing payments from non-contributing affluent states would be largely offset by the HIF's lower cost – making it realistically possible for the HIF to be launched by a few major countries.

Creation of the HIF is an extremely cost-effective reform, potentially freeing millions of mostly poor people from their debilitating ailments and greatly strengthening humanity's preparedness against communicable diseases.

References

1. Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement), Apr. 15, 1994, Marrakesh Agreement Establishing the World Trade Organization, Annex 1C, 1869 U.N.T.S. 299, 33 I.L.M. 1197 (1994).

2. Thomas Pogge, "Just Rules for Innovative Pharmaceuticals," Philosophies 7(4) (2022) 79; (link)